

00-13875

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 19956
REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--------------------------|--|---|--|-----------------------------------|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST William | | MIDDLE Stanley | | LAST | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH 7 | | DAY 3 | | YEAR 1986 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 08-15-29 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | MONTH 7 | | DAY 3 | | YEAR 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 940 Druid Hill Avenue | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST S.R. Stanley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Stevenson | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unknown | | | | 16b. SOCIAL SECURITY NO. 241-42-6759 | | | | 17. INFORMANT ADDRESS Verniece Stanley 940 Druid Hill | | | | | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Margarita A. Korell* TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7/4/86

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto., MD.

| | | | | | | | |
|--|--|---------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-7-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Southport, North Carolina | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson F.H. 1913 W. Baltimore St | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAYED, IT SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1, AND 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1871

1

1871

VOID

CERTIFICATE # 86-19957

00-13804

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 9 9 5 8

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) STANLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1986 | | | 2b. HOUR 6:00 PM | | | | |
| 3. SEX F. | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 2-28-97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1005 ALLEN ST / 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WM ROSSETT | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTA THOMAS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 219-30-7216 | | 17. INFORMANT ADDRESS Elnora Robinson 4100 MAIN AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATRIAL FIBRILLATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 30 MINUTES | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ATRIAL FIBRILLATION</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) the hospital attended the deceased from 7/26/86 to 7/26/86, and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not see the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE K. Bowers | | | DEGREE MD | | | 22c. DATE SIGNED 7/26/86 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) SIVERTSON | | | 22f. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY Dorsey Chapel | | 23d. LOCATION CITY OR TOWN COUNTY STATE NEW London MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Locks Funeral Home 1304 N. Central | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

RELEASED AS NON MED BY DR. KORELL PER MR. RICHARDSON

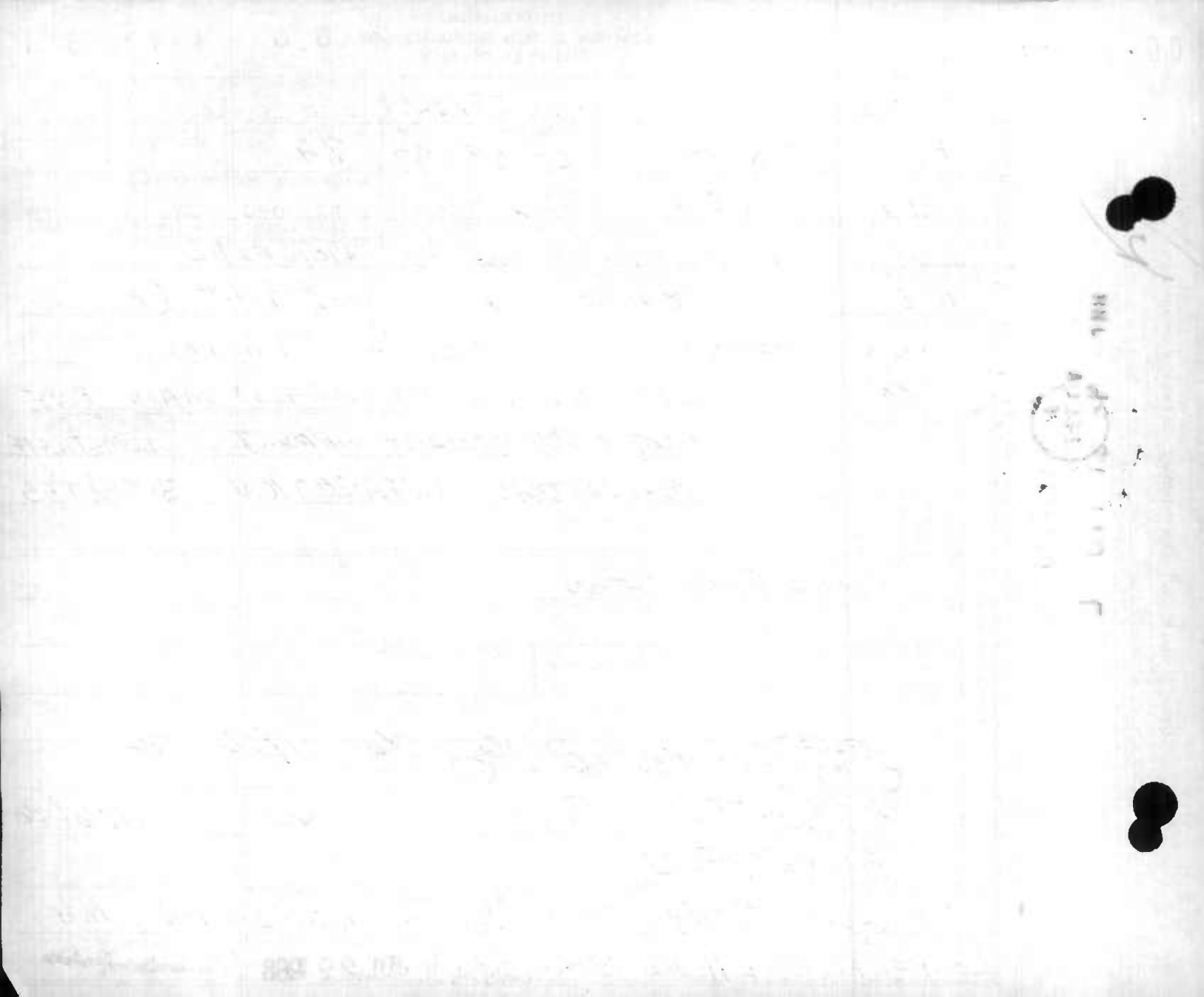
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, you may wish to have it signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the certificate from the file and it should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene (not to be sent by mail, express, or overnight).

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, a medical examiner must be notified at once.

BP



0-12346

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANTOINETTE Marie STANSBURY | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 11 86 | | | 2b. HOUR 11²³ A.M. | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 01 12 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2600 Roselawn Ave. 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Micale | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Ferrari | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 028-07-5495 | | 17. INFORMANT ADDRESS Howard R. Stansbury, Sr., Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC VENTRICULAR ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) MASSIVE ESOPHAGEAL HEMORRAGE/ESOPHAGEAL CA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10 , 19 86 , to 7/11 , 19 86 , that (I) (we) last saw the deceased alive on 7/11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE D. Hooper, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/11/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DWIGHT HOOPER, M.D. | | | | | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY OakLawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JUL 14 1986 | | |

MEDICAL CERTIFICATION

219

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be sealed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

0-7218

WINTER 1902

Mr.

W. B. L.

X

Homestead

Mr.

W. B. L.

X

3000 Roselawn Ave. 2211

Patent

W. B. L.

W. B. L.

Joseph

Mr.

1008-17-2505

Howard H. Stansbury, Sr., same as 170

Burns

7-17-85

Oakland

Baltimore, Md.

Edward J. Inc., Inc., 7707 Harbor St.

0-14177

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 19960

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST <i>Martha E Starks</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7-18 86</i> | | 2b. HOUR <i>6:45 P.M.</i> | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 27 13</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY, GIVE STREET ADDRESS) <i>Deacon Hospital Med Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NURSE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Pvt. Duty</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Foster</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nannie Williams</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>24-014994</i> | |
| 17. INFORMANT <i>217 N. MONROE STREET</i> | | 18. CAUSE OF DEATH (Enter only one cause per line form (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema, acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS HD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 yr.</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i> | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Deceitful</i> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from saw the deceased alive on <i>7/18 86</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <i>Dr. Gladu, M.D.</i> | | 22c. DATE SIGNED <i>7/21/86</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>7/23/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>MD. NATIONAL MEM. PK.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>LAUREL, MARYLAND</i> | |
| 24. FUNERAL DIRECTOR NAME <i>NUBERT SONS FUNERAL HOME, INC.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 1 1986</i> | | 25b. REGISTRAR'S SIGNATURE | | | |
| 25c. ADDRESS <i>2501 GWYNNS FALLS PKWY, BALTIMORE, MD, 21216</i> | | | | | | | |

MEDICAL CERTIFICATION

29

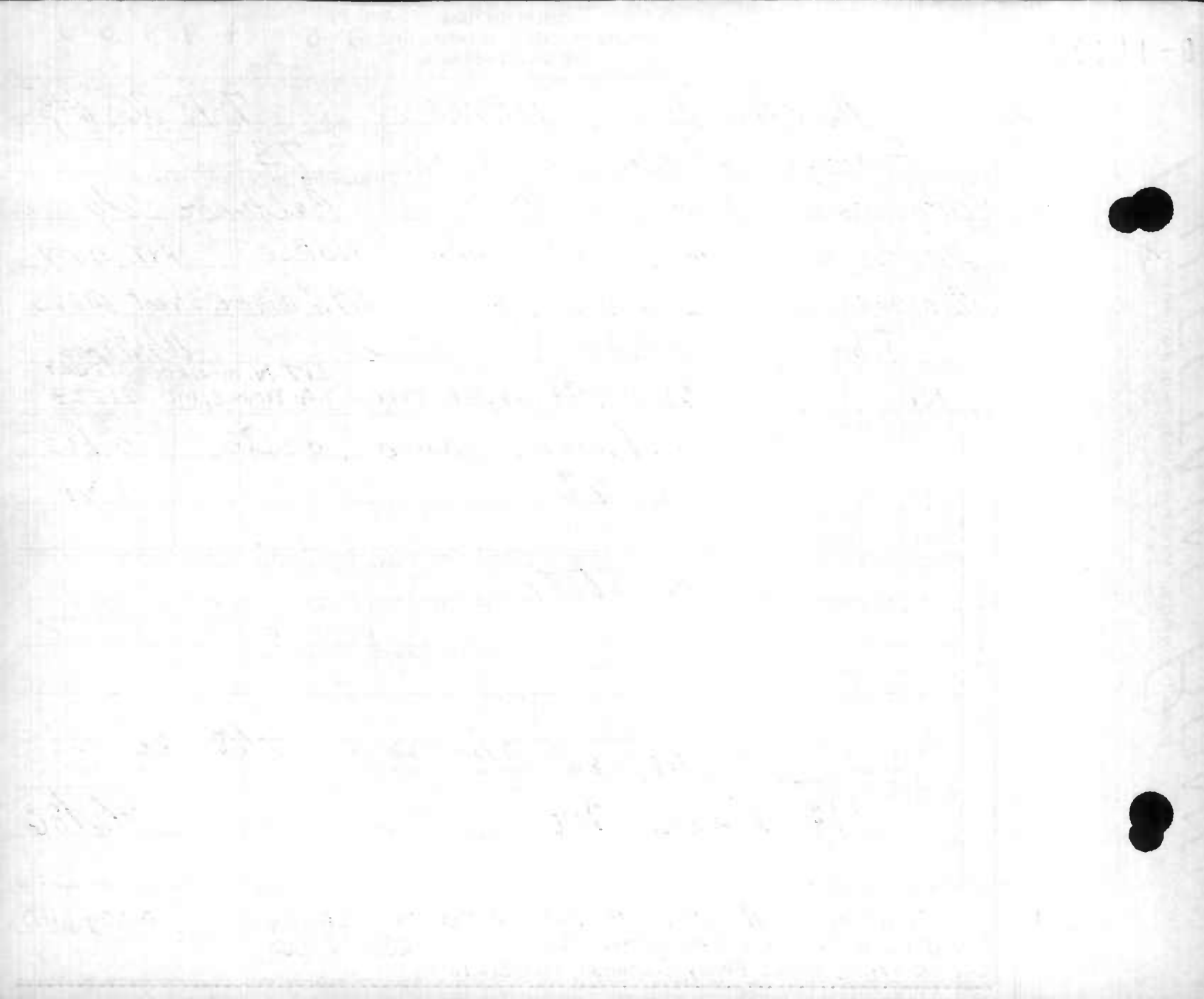
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



000-11811

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ARTHUR C STAUS III | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 2 86 | | | 2b. HOUR M | | | |
| 2. SEX MALE | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH DAY YEAR 11 12 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0.6 7 18 | | # UNDER 24 HRS. HOURS MIN. 7 18 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Middletown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 27 Boileau Court | |
| 4. FATHER'S NAME FIRST MIDDLE LAST Arthur Staus, Jr | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret O'Boyle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS Father 27 Boileau Court, Middletown, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) BRONCHO PULMONARY DYSPLASIA DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael E. Pelczar | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. PELCZAR | | | | 22e. ADDRESS ST. AGNES HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax Virginia | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Demaine Funeral Homes, Inc Alexandria, Virginia | | | | | | | | | |

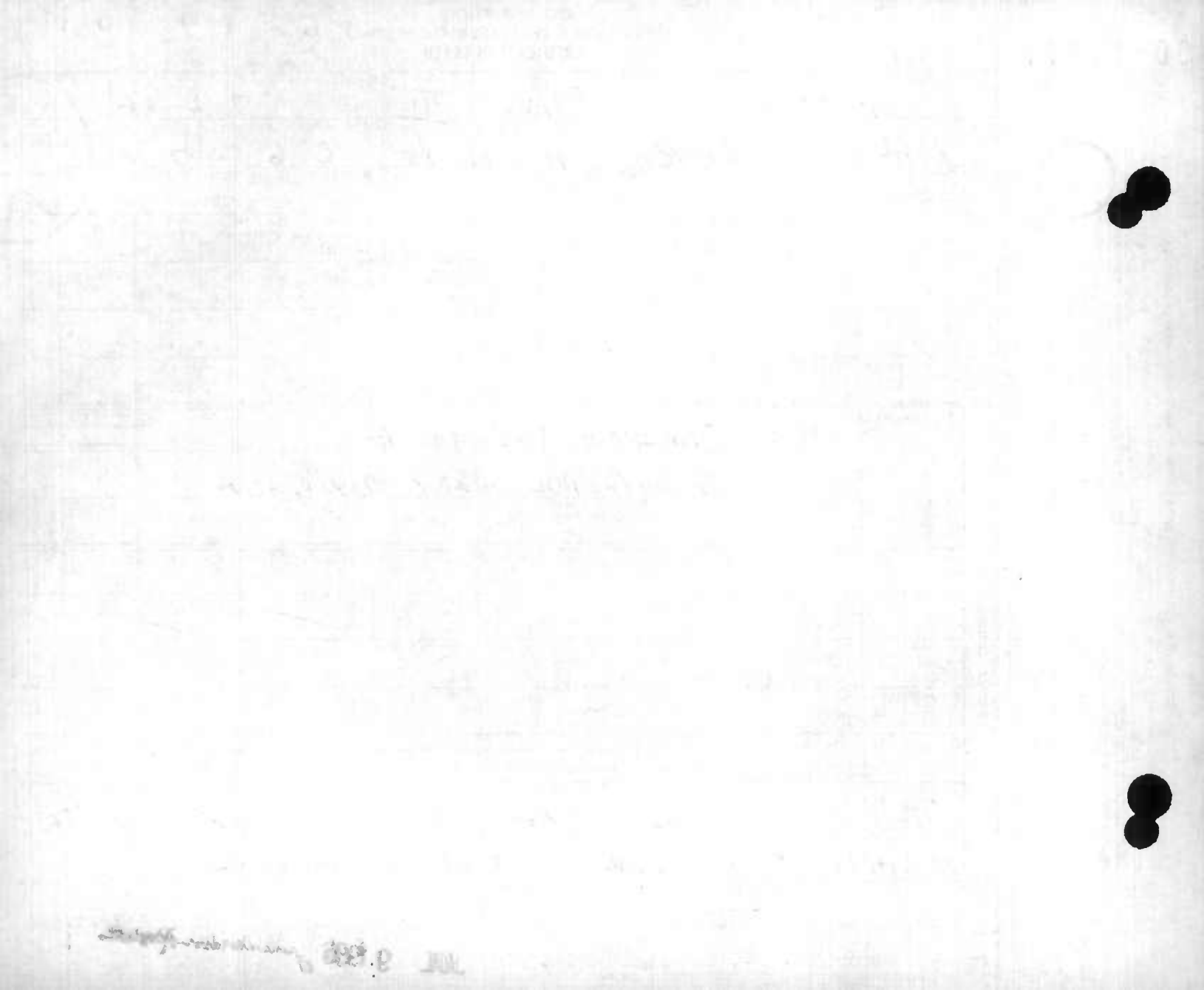
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by letter.



00-14058

21f, Film G618 8/26/86 k.m. STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

1- STATE REGISTRAR **Mathilda Barbara Stead** REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST **Mathilda Barbara Stead**

2. SEX **Female** 3. RACE **Caucasian** 4. DATE OF BIRTH MONTH DAY YEAR **12 01 1893**

5. DATE OF DEATH MONTH DAY YEAR **7 27 86** 6. AGE (IN YEARS LAST BIRTHDAY) **92** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH **Baltimore City** MD.

10. CITY OR TOWN OF DEATH **Baltimore MD** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Mercy Hospital**

12a. USUAL OCCUPATION (GIVE FULL TITLE) **Sewing Machine Operator** 12b. KIND OF BUSINESS OR INDUSTRY **Orthopedics**

13a. STATE **MD** 13b. COUNTY **Baltimore** 13c. CITY OR TOWN **Balt city** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE **600 S. Light Street/21230**

14. FATHER'S NAME FIRST MIDDLE LAST **John Rausch** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Mary Magdalen Etzel**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **No** 16b. SOCIAL SECURITY NO. **577/20/5186** 17. INFORMANT ADDRESS **Balto., Md. Anna Buckley 216 N. Kenwood Ave./21224**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Sepsis**
 DUE TO, OR AS A CONSEQUENCE OF (b) **Post necrotic cirrhosis**
 DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Fracture (R) hip

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **? P.M. 7-11- 1986** 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) **Subject fell.**

21a. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☒ AT WORK 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) **bedroom** 21c. LOCATION STREET CITY OR TOWN COUNTY STATE **600 S. Light St., Balto. MD**

22a. I certify that (I) (this hospital) attended the deceased from **19** above, (I) (we) (did) (did not) view the body after death. 19. that (I) (we) lost saw the deceased alive on **19**, and that (I) (we) (did) (did not) view the body after death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Dennis Kurgansky** 22c. DATE SIGNED **7-27-86**
 DEGREE CERTIFICATION APPROVED BY MEDICAL EXAMINER
 ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Dennis Kurgansky MD** 22e. ADDRESS **301 St Paul Place Balto MD 21203**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Cremation** 23b. DATE **7/29/1986** 23c. NAME OF CEMETERY OR CREMATORY **Green Mount Crematory** 23d. LOCATION CITY OR TOWN COUNTY STATE **Baltimore, Maryland 21202**

24. FUNERAL DIRECTOR NAME ADDRESS **Walter Brooks Bradley Inc. Balto., Md. 21222** 25a. DATE REC'D. BY REGISTRAR **JUL 30 1986** 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP

RECEIVED JAN 10 1964

00-14334

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 1 9 9 6 3
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) PATRICIA DEVAUL STEARNS | | | 2a DATE OF DEATH MONTH DAY YEAR 7-31-86 | | | 2b HOUR 6:20 P.M. | | |
| 3 SEX Female | | | 4 RACE Caucasian | | | 5 DATE OF BIRTH MONTH DAY YEAR MARCH 16, 1937 | | |
| 6a BIRTHPLACE (COUNTRY) NEW YORK | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 6 AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS 49 | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF Md. HOSP'T. | | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 1a STATE Md. | | | 13b COUNTY P.G. Co. | | | 13c CITY OR TOWN GREENBELT | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST CARROL RICE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE RADLEY | | | 12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. 108-32-4218 | | | 17 INFORMANT ADDRESS GLENN D. STEARNS (SAME AS #13) | | |
| 12c STREET ADDRESS / ZIP CODE 8503 GREENBELT RD. #T-2 | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 12b KIND OF BUSINESS OR INDUSTRY BEAUTY SHOP | | |

| | | | |
|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) abdominal liposarcoma | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/26 19 86 to July 31 19 86 that (I) (we) last saw the deceased alive on July 31 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Robert Fisher | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED July 31, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Fisher MD | | 22e ADDRESS Univ. of Md Cancer Center 32 South Greene St. Baltimore, MD 21201 | | | | | |

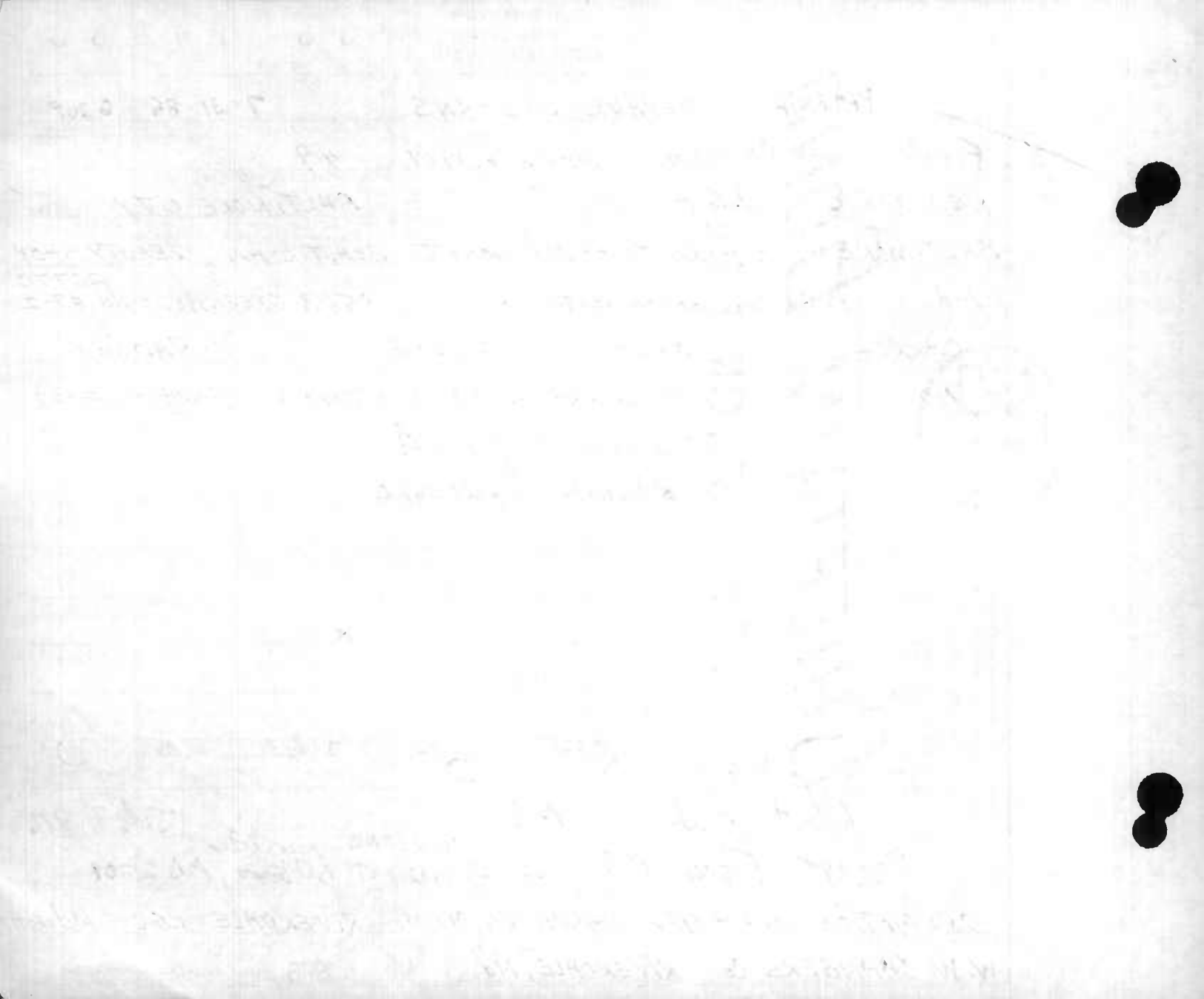
| | | | | | | | |
|---|--|---------------------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b DATE AUG. 4, 1986 | | 23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREM. | | 23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. Md. 20737 | |
| 24 FUNERAL DIRECTOR NAME W. W. CHAMBERS Co. | | | | ADDRESS RIVERDALE, Md. | | 25a DATE REC'D. BY REGISTRAR AUG 5 1986 | |
| | | | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | REG. NO. | | 19964 | | DATE OF DEATH | | 7 15 86 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | |
| AMANDA | | ANNA | | STEIN | | | | 7 15 86 | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | White | | 4 24 1900 | | 86 | | 5:45P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Bon Secours Hospital | | Hwf | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Baltimore | | | | Md. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1213 Light St. 21230 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| Joseph | | Sewell | | Amanda | | 220-05-1693 | | Mr. Frederick A. Stein, Westminister Md. 21157 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia | | DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) dehydration & uremia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 86, to 7/15, 19 86; that (I) (we) last saw the deceased alive on July 15, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| | | Ray Brodie Jr | | MD | | 7/17/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Dr Ray Brodie Jr | | 844 N. Carey St 21217 | | Cremation | | 7-18-86 | | Carroll Cremation | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 23d. LOCATION | | 23e. COUNTY | |
| Eline Funeral Home | | JUL 23 1986 | | [Signature] | | Hampstead | | Carroll Md. | |
| NAME | | ADDRESS | | | | | | | |
| Eline Funeral Home | | Hampstead, Md. | | | | | | | |

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "COLUMBIA" and "SOUTH" are faintly visible.]



0-13734

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 9 9 6 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FREDERICK J. STENCIL Sr. | | | 2a. DATE OF DEATH MONTH 07 DAY 25 YEAR 86 | | | 2b. HOUR 1:48 AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 01 DAY 21 YEAR 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS 00 DAYS 00 | | IF UNDER 24 HRS HOURS 00 MIN. 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY Heating/Air Cond. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1721 Clarkson St 21230 | | | |
| 14. FATHER'S NAME FIRST Michael MIDDLE --- LAST Stencil | | | | 15. MOTHER'S MAIDEN NAME FIRST Loretta MIDDLE --- LAST Abel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 412-07-7663 | | 17. INFORMANT John Coady | | 21061 ADDRESS Glen Burnie, Md. | | 502 Delaware Ave - Son | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks 10+ yrs. | |
|--|--|---|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cachexia, Pernicious Anemia | | | |
|--|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

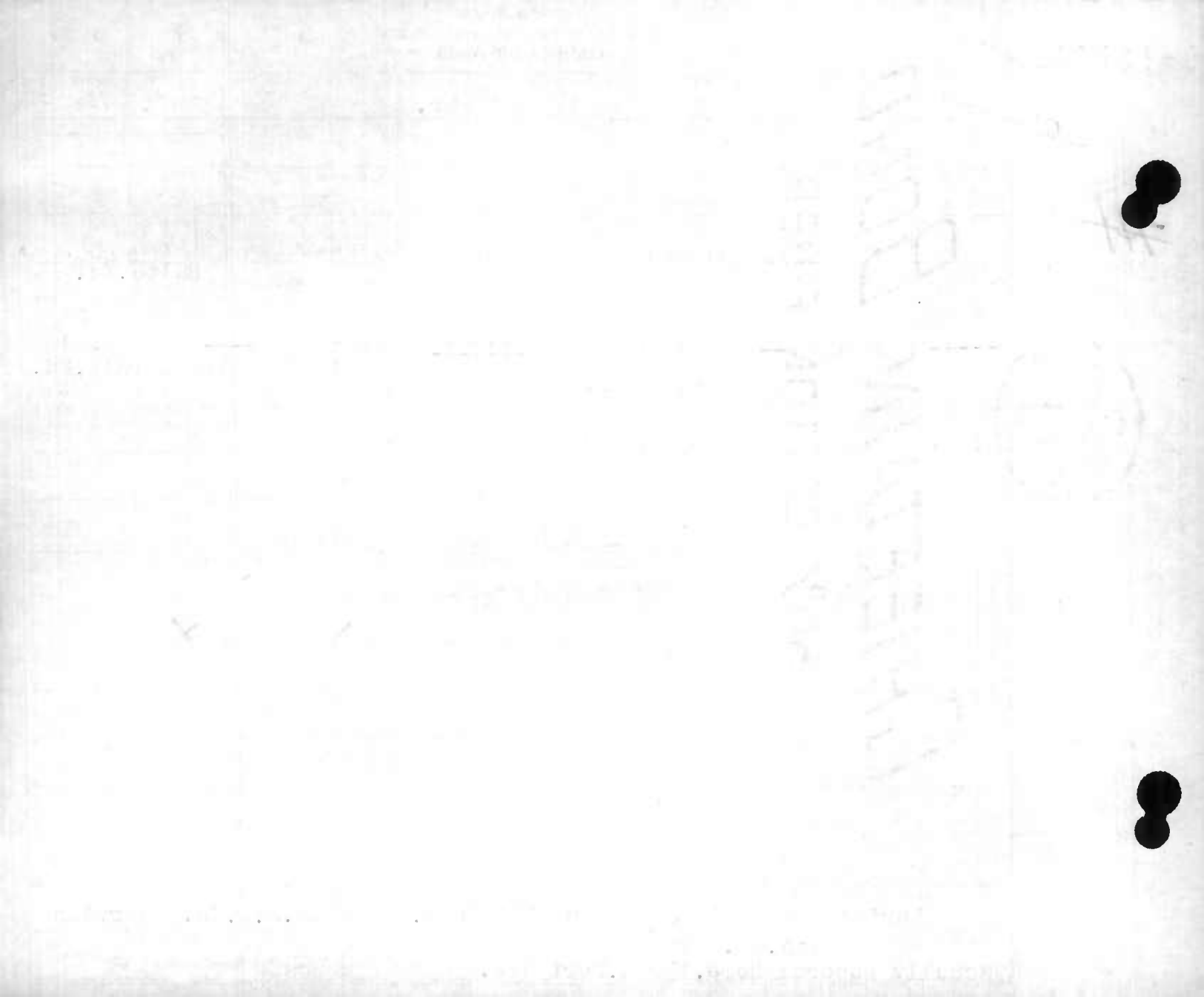
| | | | | | | | |
|---|--|-----------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE H. R. Watson | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-25-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Waite, M.D., MPH | | | | 22e. ADDRESS 3001 S Hanover St, Baltimore MD 21230 | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/28/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt. | | 23d. LOCATION CITY OR TOWN Balto.A.A.Co. COUNTY Maryland STATE | |
|--|--|-------------------------------|--|---|--|---|--|

| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Balto.Md.21230 ADDRESS McCully Funeral Home, 130 E. Fort Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson | |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and returned to the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-12182

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Hatten, B/B-Linda 221 78 58

Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The following requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|---|--|--------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7. REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LONEY STEVEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1986 | | | 2b. HOUR 9:00A _M | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 6 13 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 25 | | 7. IF UNDER 1 YEAR MONTHS DAYS 25 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? u.s.a. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Steven L. Loney Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Hatten | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. unk. | | 17. INFORMANT ADDRESS Linda Hatten 214 N. Washington Street | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Prematurity</u> | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 4d 24d | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Arnon Zuckerberg</u> | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/7/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arnon Zuckerberg | | | | 22e. ADDRESS MD 600 N. WOLFE ST BALTO 21205 Johns Hopkins Hospital 600 N. Wolfe Balt. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Linda Hatten</u> | | |

BP

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2020 1500 2020 1500 2020 1500

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00-13231

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 19967

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Victoria S. Stevens | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 19 1986 | | | 2b. HOUR M | | | |
| 3. SEX Female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 10 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1630 West Fayette Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|--|
| 13a. STATE Md | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1630 W. Fayette Street 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alonzo Smith | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Watson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239-26-1514 | | 17. INFORMANT ADDRESS Alice Cooper 3400 Edgewood Road | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia, hyperkalemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Suspect occult carcinoma</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>N/A</u> | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION <u>N/A</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/1/86</u> 19 <u>85</u> , to <u>5/22</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/22</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Karen Trent MD.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>7/21/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAREN TRENT MD.</u> | | | | 22e. ADDRESS <u>1701 W. PRATT ST. BALTO. 21223.</u> | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 24 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

50991 00

100-1-00

20% COTTON FIBER

MADE IN U.S.A.



0-14145

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASON FOR DELAY IN ITEM 19. THIS CERTIFICATE, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (5))

| 1- FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. 19968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|-------------------|--|----------------|--|--|--|--------------------------|--|-------|--|-----|--|------|--|---|--|------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Troy Stevenson | | | | | | | | | | 7-23 1986 | | | | | | | | | | 3:07 p.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | MIN. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | C | | 6-18-86 | | YRS. 1 | | MONTHS 5 | | DAYS 5 | | 7-23 1986 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BALTIMORE MD | | | | | | | | | | U.S.A. | | | | | | | | | | BALTIMORE CITY, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | | | | | | | | University Hospital | | | | | | | | | | CHILD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | | | | | | | | | | | | | | | | | | | BALTIMORE | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 931 SEAGULL AVE 21226 | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TROY STEVENSON | | | | | | | | | | TRACY WINNMAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | | | | | | | | | | | | | | | MRS Y STEVENSON | | | | | | | | | | 21225 3474 SPENCER RD | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Digitalis Intoxication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8583 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Congenital Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR ? P.M. 7-23 1986 | | | | | | | | | | subject given incorrect dosage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | Home | | | | | | | | | | 931 Seagull Avenue, Baltimore, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| death resulted from: | | | | | | | | | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | | | | | | | Assistant | | | | | | | | | | 7-25-86 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | | | | | | | 111 Penn St., Balto., Md. | | | | | | | | | | 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | 7-26-86 | | | | | | | | | | Mt Zion Cem | | | | | | | | | | BALTO CO MD | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Vossler L. Russ | | | | | | | | | | 22224 NORTH AVE | | | | | | | | | | AUG 1 1986 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

1. The first part of the report is a general statement of the work done during the year.

2. The second part is a statement of the work done during the year.

3. The third part is a statement of the work done during the year.

4. The fourth part is a statement of the work done during the year.

5. The fifth part is a statement of the work done during the year.



6. The sixth part is a statement of the work done during the year.

7. The seventh part is a statement of the work done during the year.

8. The eighth part is a statement of the work done during the year.

9. The ninth part is a statement of the work done during the year.

10. The tenth part is a statement of the work done during the year.

11. The eleventh part is a statement of the work done during the year.

0-13923

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 9 9 6 9
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frederick Stewart | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/30/86 | | | 2b. HOUR 8 M | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Radford, VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3324 Ingleside Ave. 21215 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | 13b. COUNTY None | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3324 Ingleside Ave. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Stewart | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Jones | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 0 | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 218-18-5449A | | 17. INFORMANT ADDRESS Jessie Stewart, 3324 Ingleside Ave. 21215 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Carcinoma Lung Metastatic

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/17/86</u> to <u>7/30/86</u> , that (I) (we) lost <u>7/30/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>7/30</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Reisman</u> | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave. 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 31 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |

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0-11551

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 9 7 0

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth Stine | | | 2a. DATE OF DEATH MONTH DAY YEAR July 1, 1986 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 04 28 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 8203 Watersedge Road 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Allaire | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Heiser | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 068-14-4439 | | 17. INFORMANT ADDRESS Hugh E. Stine Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Obesity | | | | | |
| 19a. DATE OF OPERATION N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE G. Madhviraju M.D. | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/2/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Govindaraju Madhiraju M.D. | | | 22e. ADDRESS 201 Ballard Ave. Baltimore, MD 21220 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/5/1986 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Ave Balto Md 21222 | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE Govindaraju M.D. | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-12798

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed at death.

Cert. amended by M.E. 9/3/86 dad

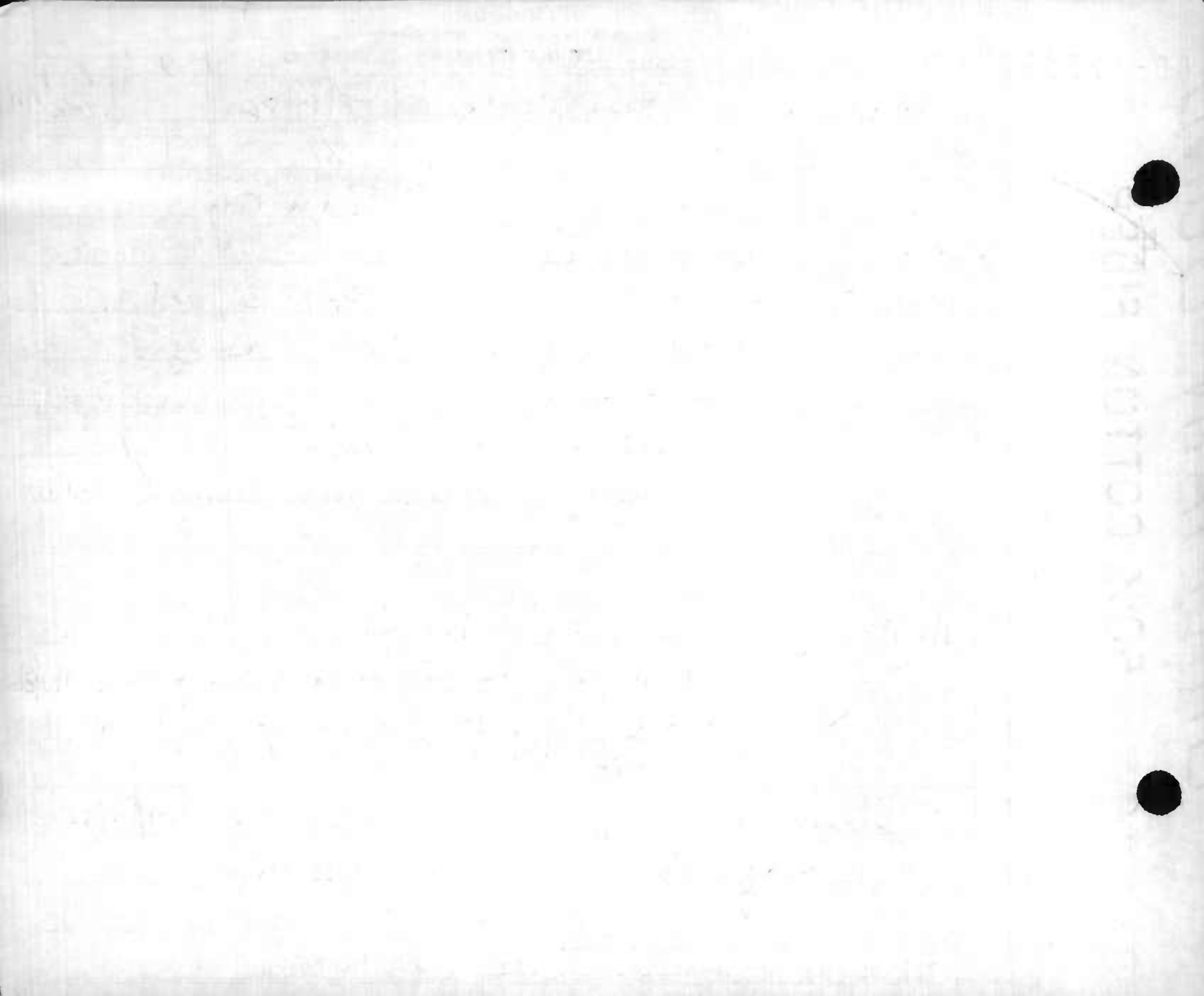
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR **Marcella Stradsaukas**

REG. NO. **19971**

| | | | | | |
|---|--|---|---|---|----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Marcella Stradsaukas | | | 2a. DATE OF DEATH MONTH 7 DAY 17 YEAR 86 | | 2b. HOUR 1208 PM |
| 3 SEX Female | 4 RACE Cauc. | 5. DATE OF BIRTH MONTH 9 DAY 7 YEAR 04 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lith. | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Balt City MD. | | |
| 10 CITY OR TOWN OF DEATH Balt City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | 12b KIND OF BUSINESS OR INDUSTRY Clothing | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. CITY OR TOWN Balt | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 907 Bayard St. 21223 | | | |
| 14 FATHER'S NAME FIRST Valerian MIDDLE Stradsaukas LAST Stradsaukas | 15. MOTHER'S MAIDEN NAME FIRST Marcella MIDDLE Dargis LAST Dargis | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b SOCIAL SECURITY NO. 213-104591 | 17. INFORMANT ADDRESS Joseph Stradsaukas, 2606 Beckleysville Rd., Freeland, Md. 21053 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 8809 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Subdural + Intracerebral hemorrhage 6 days DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a DATE OF OPERATION 7/11/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural + Intracerebral Hematoma | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR 3 A.M. MONTH 7 DAY 11 YEAR 86 | 21c. HOW INJURY OCCURRED - (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Pt found @ bottom of stairs 7/11/86 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home | 21f. LOCATION STREET 907 Bayard St CITY OR TOWN Balt COUNTY MD STATE MD | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11/86 to 7/17/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John Kephau | | DECEASET approved by Dr. A. Dixon ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raphy | | 22e. ADDRESS Univ of MD Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/21/86 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 23d. LOCATION CITY OR TOWN Balto., Md. COUNTY STATE | | |
| 24. FUNERAL HOME NAME Chimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Balto., Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986 | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP



00-11973

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 9 9 7 2

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|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Frederick Conrad Stock | | July 8, 1986 | | 4:20 P. | |
| 1. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12-31-1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Printing Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3621 Gibbons Ave. 21214 |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Stock | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Cunningham | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII | | 16b. SOCIAL SECURITY NO. 215-10-8908A | 17. INFORMANT ADDRESS Phyllis Stock, Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: na | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 8/10 , 19 81 , to 4/9 , 19 86 , that (b) (we) last saw the deceased alive on 4/9 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Miguel Karacuschansky</i> | | DEGREE M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 7-9-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL KARACUSCHANSKY | | 22e. ADDRESS 300 E. 33rd St Balto Md. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-12-86 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc | | Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JUL 10 1986 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

4:30 P.

July 8, 1900

Stock

Quoted

Provision

Rate

12-11-1912

White

Id.

U.S.A.

Baito, City

Baito.

Good Samaritan Hospital

Ref. Salomon Printing Co.

Id.

Baito.

701 Gibbons Ave. Baito

John

Stock

Id.

Id.

Cunningham

Yes

Id.

212-10-10000 Baito Stock, same as 120

A. J. WEST

Id.

Baito, Id.

Id.

Id.

Id.

Id.

00-12139

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS OCCUR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW-2 (SEE PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 19973 | |
|---|--|---|--|---|---|--|--|---|--|--|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Frederick Strassheim Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR | |
| 3. SEX Male | | | | | | | | | | 2b. HOUR 1:45 | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 1917 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | 7. DATE PRONOUNCED DEAD MONTH 7 DAY 9 YEAR 1986 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hand Compositor | | 12b. KIND OF BUSINESS OR INDUSTRY Waverly Press | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3715 Lyndale Ave. 21213 | | | |
| 14. FATHER'S NAME FIRST Frederick MIDDLE Strassheim LAST Emmert | | | | | 15. MOTHER'S MAIDEN NAME FIRST Kate MIDDLE Emmert LAST Emmert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | (IF YES, GIVE WAR OR DATES) WW II | | 16b. SOCIAL SECURITY NO. 212-07-1432 | | 17. INFORMANT ADDRESS Evelyn Strassheim (wife) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE Margarita A. Korell | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7/9/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn St. Balto.MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|---------------------|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HENRY MARVIN STREET | | | 2a. DATE OF DEATH MONTH DAY YEAR July 31, 1986 | | 2b. HOUR 7:30p M | | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 12 14 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTI MORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY CONSOLIDATED | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILL STREET | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE JACKSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 245 07 7241 | | 17. INFORMANT MRS. LOIS H. STREET | | 719 RICHWOOD AVENUE BALTIMORE, MARYLAND 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lung cancer</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> , 19 <u>86</u> , to <u>July 31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE David L. Dunnigan | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 8/1/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID L. DUNNIGAN, MD. | | | | 22e. ADDRESS Loch Raven V. A. medical center 3900 Loch Raven Blvd., Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8/6/1986 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VETERAN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 8 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

ADP13 MOTION NO3

DND

MAATE



00-11668

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 9 7 5

1. FOR
STATE
REGISTRAR

| | | | | |
|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Antoinette Strejcek ELIZABETH STREJCEK | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1986 | | 2b. HOUR 11:50 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 21, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY? -U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY --- 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 11 S. Curley Street 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank A. Reis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Holstein | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-8288 | | 17. INFORMANT Baltimore, Md. 21224. Joseph J. Strejcek-11 S. Curley St |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) --- | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CELLULITIS OF LEG, STAPHYLOCOCCUS SEPSIS, RESPIRATORY FAILURE | | | | |
| 19a. DATE OF OPERATION JUNE 27, 1986 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LUNG CANCER-BRONCHOSCOPY | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JUNE 11, 1986 , to JULY 1, 1986 , that (I/we) last saw the deceased alive on JULY 1, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | |
| 22b. SIGNATURE C.S. Ramsey D.O. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL S. RAMSEY D.O. | | 22e. ADDRESS CHURCH HOSPITAL 21231 100 N. BROADWAY, BALTIMORE, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/5/86 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home 3000 E. Baltimore St., Balto., Md. 21224. JUL 8 1986 | | | | |

Alfred H. Anderson, Jr.

June 21, 1910

to

John W. McLaughlin, Jr., Baltimore City

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 17th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours very truly,
Alfred H. Anderson, Jr.



RECEIVED
JUN 22 1910
BALTIMORE CITY POLICE DEPARTMENT
JUN 22 1910

00-11473

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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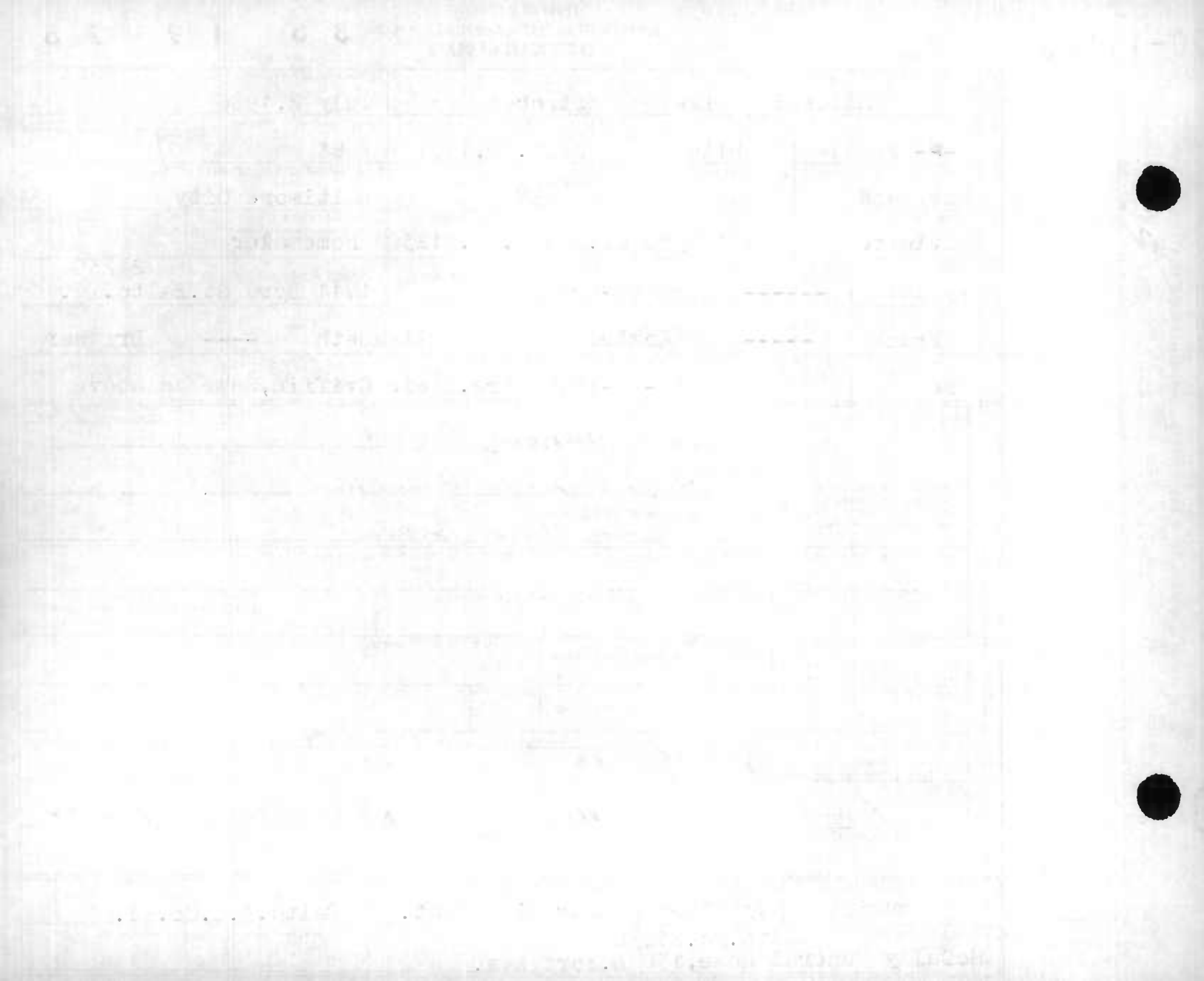
REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Lee Strobel | | | 2a. DATE OF DEATH MONTH DAY YEAR July 2, 1986 | | | 2b. HOUR M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1711 Byrd St. Balto. Md. 21230 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1711 Byrd St. Balto. Md. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank ----- Eckles | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth ----- Bridner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-20-4575 | | 17. INFORMANT ADDRESS Mrs. Elsie Griffin, Same as above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Right upper lobe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Purulent Abscess Brain | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 82 to July 19 86 , that (I) (we) lost saw the deceased alive on July 28 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Sandra L. Handman | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7-2-86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/5/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR (NAME) McCully Funeral Home, 130 E. Fort Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-11532

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|-----------------------------|--|------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7 | | 3 | |
| JAMES | | E. | | STRUMSKY | | | | 86 | | 10:15A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | MONTH DAY YEAR | | 69 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Baltimore City | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 2625 Georgetown Road | | Disabled | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS / ZIP CODE | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2625 Georgetown Road, 21230 | | | |
| Maryland | | | | Baltimore | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| August | | Emilia | | M. | | Suber | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 218-05-9348 | | David J. Strumsky, 2697 Dulany St., 21223 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | Vascular Thrombosis | | | | | | | |
| | | (c) | | Vascular Thrombosis | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1986 to 7/5 1986 that (I) (we) lost | | | | | | | | | | | |
| saw the deceased alive on 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22d. ADDRESS | | | | | | | | | |
| Barr | | 3455 Wilkens Avenue Room 304 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 7/5/86 | | Meadowridge Mem. Park | | Elkridge Howard Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | JUL 7 1986 | | Julia Davidson | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 9 9 7 8

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emmett J Sullivan SR. | | 2a. DATE OF DEATH MONTH DAY YEAR 07 24 86 | | 2b. HOUR 2307 hr | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY Steamship Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Sullivan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella T. Byrne | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 215-03-1857 | | 17. INFORMANT ADDRESS Mrs. Mary A. Sullivan same as # 13 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2° Dysrhythmias APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 07-24-86 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction 07-22-86 DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Randeep S. Mann | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 07-24-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANDEEP S. MANN | | 22e. ADDRESS 5601 Loch Raven Blvd. Baltimore, MD 21203 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | ADDRESS 5305 Harford Road 21214 | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be consulted at once.

ORGAN DONOR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file a report on page 4.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 1 9 9 7 9 REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RHONDA SUMMERFIELD | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1986 | | | | | | | | | | 2b. HOUR 8:05 P M | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1958 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR 27 | | | | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacy Tech. | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Drug Store | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Allegany Rawlings | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE none 41557 | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Donald L. Robinette | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosannah Hendrickson | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | | 16b. SOCIAL SECURITY NO. 216-72-7139 | | | | | 17. INFORMANT ADDRESS Husband Mr. James B. Summerfield, Rawlings, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST (BRAIN DEATH) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HERNIATION SYNDROME (c) CORONARY BLOOD VASCULAR OCCLUSION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NOT APPLICABLE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION NA | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY NA HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED NA WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY NA (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/29 1986, to 7/31 1986, that (I) (we) last saw the deceased alive on 7/31 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE DEGREE Brenda C. McLean, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 7/31/86 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRENDA C. McLEAN, M.D. | | | | | 22e. ADDRESS 600 Wolfe St. Black 14 BALTIMORE MD. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 8-3-1986 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rawlings, Md. allegany | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, Md. 21502 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 6 1986 | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 19980

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSG SUNDHEIMER | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 27 1986 9:45 AM | | 2b. HOUR |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 22 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINSON HEBREW GERIATRIC CENTER + HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST VICTOR LOWENSTEIN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA SCHLOSS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 098-28-7843 | 17. INFORMANT ADDRESS ERNEST SUNDHEIM 3312 MENLO DR. 21215 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RECURRENT ASPIRATION PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

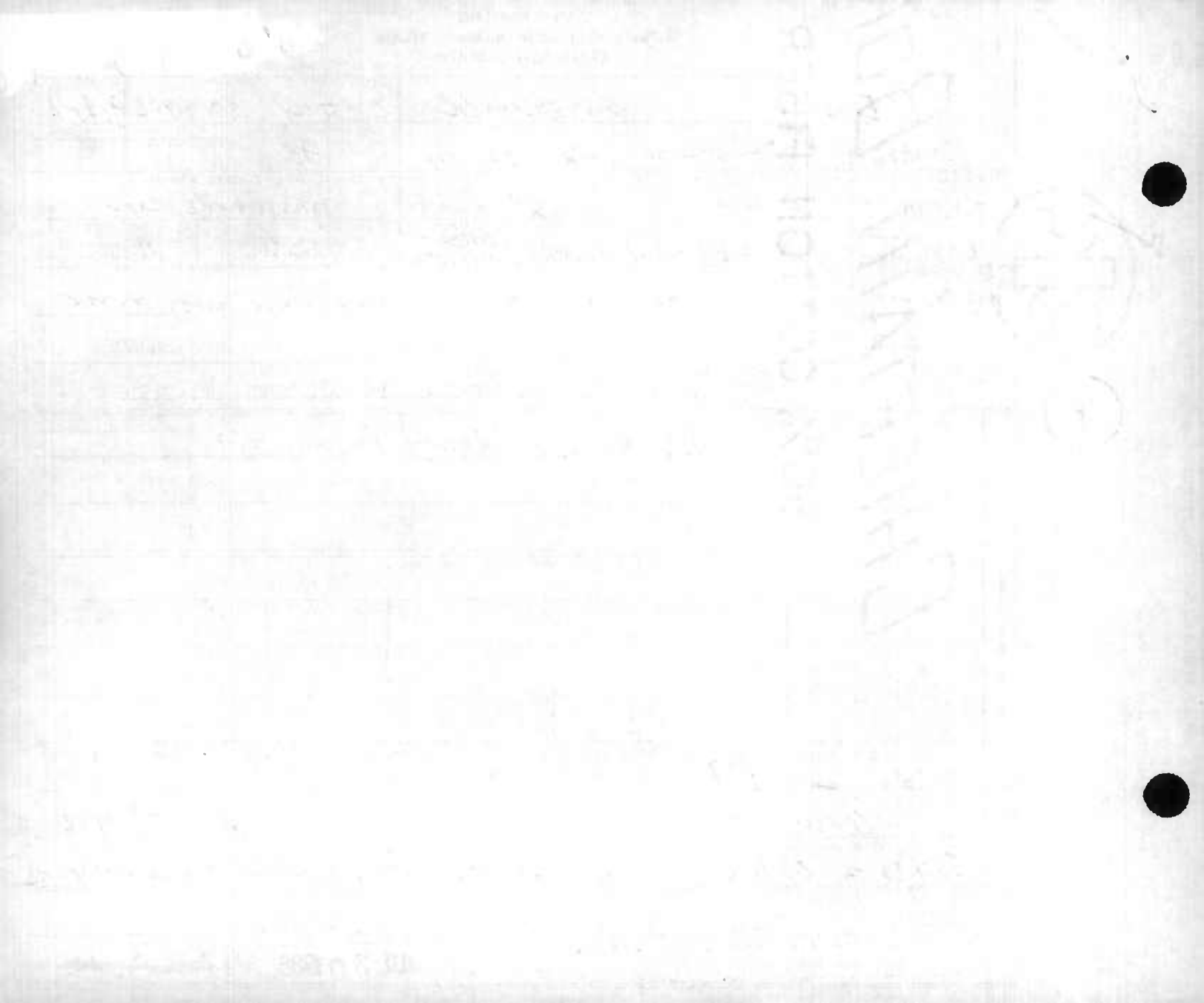
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 7/1 , 19 86 , to 7/27 , 19 86 , that (we) lost saw the deceased alive on 7/27 , 19 86 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE E. O. KUL | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/28/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELLITA O. KUL | | 22e. ADDRESS LEVINSON HEBREW GERIATRIC CENTER + HOSPITAL | |

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 7/28/86 | 23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESED | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | 25a. DATE RECEIVED BY REGISTRAR JUL 30 1986 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |



00-14046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19.981

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|-------------------------|---|--|---|---|---|---|--|------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) XXXX ALLAN E. Swartz | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-20 1986 | | | 2b. HOUR M | | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 8 4 1942 | 6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 7-25 1986 | | | 2d. HOUR 10:00 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 W. 39th St., Apt. 1308 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED | | 12b. KNOWN BUSINESS OR INDUSTRY OPTICAL-EXPORT | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. 1308 116 W. INIVERSITY PKWY., 21210 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH SWARTZ | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY FISHMAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218-42-1545 | | 17. INFORMANT MR. JOSEPH SWARTZ 7 SLADE AVE., APT. 718 #21208 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | |
| 20. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | TITLE (SPECIFY) Assistant | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CONG. | | 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1986 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

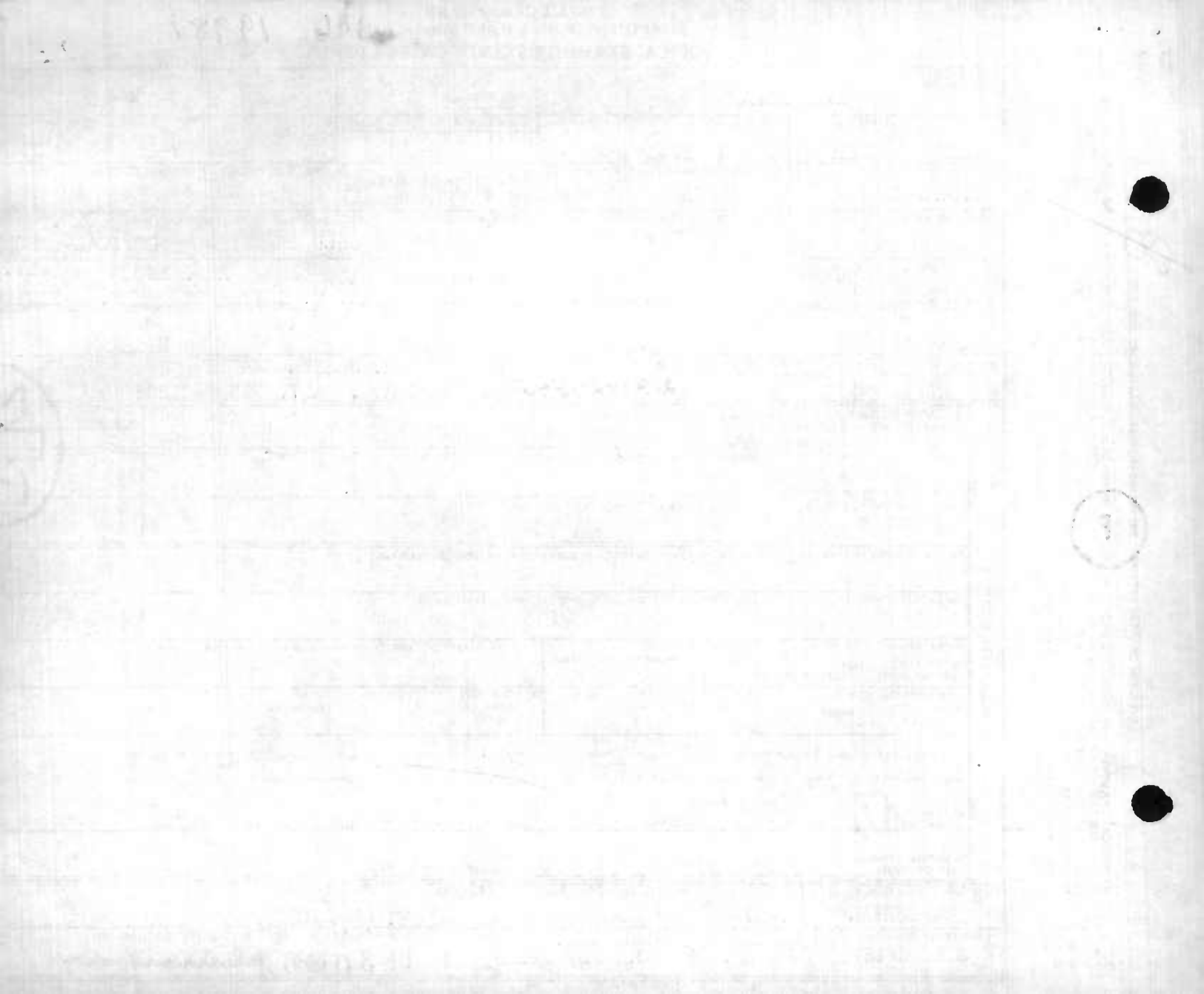
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, either any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| Item 5 Film G616 6/27/86 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL E. SYKES | | | | | | | | | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 6 30 1909 | | 7a. DATE OF DEATH MONTH DAY YEAR JUNE 17, 1986 | | 7b. HOUR 5:30 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman | | 12b. KIND OF BUSINESS OR INDUSTRY Congoleum | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Finksburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1001 Ridge Rd. 21048 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Joseph Sykes | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Anna Elizabeth Walsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) na | | 17. INFORMANT Grace Sykes | | ADDRESS 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) GANGRENE BOTH FEET X ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JUNE 16, 1986 , to JUNE 17, 1986 , that (I) (we) lost saw the deceased alive on JUNE 17, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Sompalli Prasad</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SK. PRASAD SOMPALLI | | | | 22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY, BALTIMORE, MARYLAND 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Wesley U. M. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Robert K. Pritts, Sr., Westminster, MD | | | | | | | | | |
| 25a. DATE RECD. BY REGISTRAR JUN 24 1986 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <i>Julia Bender-Randall</i> | | | | | | | | | |

00-13321

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6619483

| | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET VIRGINIA SZARKO | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 / 22 / 86 | | 2b. HOUR 6 25 AM | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 9 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 (RS) | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Russell | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georiana Kraft | | 13e. STREET ADDRESS / ZIP CODE 1031 Courtney Road 21227 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-01-1316 | | 17. INFORMANT ADDRESS Michael L. Szarko 1031 Courtney Rd. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Possible peritonitis due to perforated ulcer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-4</u> 19 <u>86</u> to <u>7-22</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>7-21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gregory S. Gordon MD</u> | | | | DEGREE MD | | 22c. DATE SIGNED 7-22-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory S. Gordon MD | | | | 22e. ADDRESS St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | | ADDRESS 21229 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

BP

28-2-1

18-21-00

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00-13669

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8619984

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Szmajda | | FIRST Carl | | MIDDLE H | | LAST Szmajda | | 2a. DATE OF DEATH MONTH DAY YEAR 7 23 86 | | 2b. HOUR 3:40 P.M. | |
| 3 SEX M | | 4 RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 4 26 56 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 30 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 30 | | IF UNDER 24 HRS. HOURS MIN. 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Coast Guard | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE NY | | | | | | 13b. COUNTY Governor's Island | | 13c. CITY OR TOWN Bldg 844, Apt 3D | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. OTHER'S NAME FIRST MIDDLE LAST Stanley Szmajda | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia Pace | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) USCues + 6-11-11-11 213-68-0832 | | | | 17. INFORMANT Carol Szmajda | | | | ADDRESS 3926 Kenyon Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Esophageal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 29, 1986 , to July 23, 1986 , that (I) (we) lost saw the deceased alive on July 23, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Mary T Behrens | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/23/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY T Behrens | | | | | | 22e. ADDRESS University Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-1986 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR JUL 25 1986 | | | |
| 24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc. | | | | | | ADDRESS 401 S. Chester St. | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1949



UNIVERSITY OF MICHIGAN

00-14168

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|-----------------------|---|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas (nmi) Szpara | | | 2a. DATE OF DEATH MONTH DAY YEAR July 30, 1986 | | 2b. HOUR 1:00 p.m. | | | | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2006 E. Lombard Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Man | | 12b. KIND OF BUSINESS OR INDUSTRY Quarrymen Cont. | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2006 E. Lombard St. #21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Szpara | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Zubrowski | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Walter Szpara | | ADDRESS 9105 Deborah Ave. #21236 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension - Hx of Cardiac Angina</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5-30-86/1986, to 7-30-86, that (I) (we) lost saw the deceased alive and about (I) (we) (did not) view the body after death, and that (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE <u>Theodore Niznik Jr.</u> | | | | 22c. ADDRESS 429 S. Chester Street - #21231 | | | | 22d. DATE SIGNED 8-1-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore Niznik Jr., M.D. | | | | 22e. ADDRESS 429 S. Chester Street - #21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. | | | | ADDRESS -705 S. Ann St. | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John A. ...</u> | | | |

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7-10-1968

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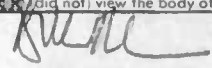
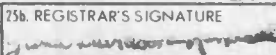
• 2011 •

00-13991

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 - 19986

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 26 1986 | | | 2b. HOUR 9:00 PM | | | | |
| 3. SEX MALE | | 4. RACE CAUASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 76 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIMLICO MANOR NURSING HOME | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | 15. KIND OF BUSINESS OR INDUSTRY Hotel | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | 16. STREET ADDRESS / ZIP CODE 1531 W. 36th Street 21211 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 215-12-9688 | | 17. INFORMANT Robert J. Tara | | | | 17. ADDRESS Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) PVD | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from 24 JULY , 19 86 , to 26 JULY , 19 86 , that (I) (we) last saw the deceased alive on 26 JULY , 19 86 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE  | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 07-26-86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR M. LEBSON, M.D. | | | | 22e. ADDRESS 3640 FORDS LANE BALTIMORE 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co., Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 31 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Total

Plumber

Unknown

Tape

Joseph

No

Robert J. Tins

3-10-44

Ad.

Ed.

Edith

7-60-86

Edith

Henry W. Jenkins & Son Co., Bldg., W.

00-13037

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 REG. NO. 19987

FOR
STATE
REGISTRAR

| | | | | | | |
|---|---------------------|---|--|---|-------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Glady's E. Taylor</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7 16 86</i> | | 2b. HOUR MIN. <i>12 45</i> AM | |
| 3. SEX <i>F</i> | 4. RACE <i>B</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>02 05 1919</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>67</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>Country</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Balto, Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i> | | |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>Balto</i> | | 13c. CITY OR TOWN <i>Balto</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Otis Marshall</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Wise</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>142-12-3042</i> | | 17. INFORMANT ADDRESS <i>Mrs. Emma Pearl 3000 Woodland Ave.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RECURRENT PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF <i>SEPSIS</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>CEREBROVASCULAR ACCIDENT, CHRONIC RENAL F</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/16</i> , 19 <i>86</i> , to <i>7/16</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>7/16</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Amelia Woreta</i> | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>7/16/86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AMELIA WORETA</i> | | 22e. ADDRESS <i>LUTHERAN HOSPITAL, BALTO, MD</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7-19-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto Md</i> | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>JAS. A. Morton & Sons - 1701 Laurens ST.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 21 1986</i> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP



00-09111

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 14, Film G616 6/18/86jab

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO. 9989

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOUISE A. TAYLOR | | | 2a. DATE OF DEATH MONTH DAY YEAR 06 08 86 | | | 2b. HOUR 2 ⁰⁰ AM | | | |
| 3 SEX F | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 01 16 45 | | 6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | | 7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINCE OF BALTIMORE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Provident Hospital Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | 13b. COUNTY None | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE 4211 Chatham Road 21207 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alfred Avon Bellamy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris White | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 0----- | | | 16b. SOCIAL SECURITY NO. 219-40-0624 | | 17. INFORMANT Richard Taylor, 4211 Chatham Road 21207 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pericardial metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>05/25</u> , 19 <u>86</u> , to <u>06/08</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>06/08</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Frederico J. Winkler</u> | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICO J WINKLER | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave. 21215 | | | 25a. DATE REC'D. BY REGISTRAR JUN 11 1986 | | REGISTRAR'S SIGNATURE <u>Frederico J. Winkler</u> | | | | |

11-22-00

11-22-00

00-12132

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND TAYLOR | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 9 86 | | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 21 1949 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 914 Mt. Holly St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Arthur Taylor | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Maude Wallace | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-60-2956 | | 17. INFORMANT William Taylor | | ADDRESS 1108 Calhoun St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACQUIRED IMMUNE DEFICIENCY SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AIDS Encephalopathy</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u> <u>18 mon</u> <u>6 mon</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>86</u> , to <u>June</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>June 20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Cheryl L Newman MD</u> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>7/9/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHERYL L NEWMAN, MD | | | 22e. ADDRESS BLALOCK 1107 JOHNS HOPKINS HOSP | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H West | | | ADDRESS 4300 Wabash Ave. | | | 25a. DATE REC'D. BY REGISTRAR JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John Darden</u> | |

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Amesbury, Mass.

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00-13652

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 19990

| | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William M Taylor SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/23/86 | | | 2b. HOUR 12:45 M | | | | |
| 3. SEX m | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 17 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Ctr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2705 E. Federal St. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walden Taylor | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Dickson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 081-14-3236 | | 17. INFORMANT Dorothy Taylor 2705 E. Federal Street. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u> | | | | | | | | | | |
| 9a. DATE OF OPERATION — | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> , 19 <u>86</u> , to <u>July 23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Robert Study MD, PhD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/23/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Study MD, PhD | | | | | 22e. ADDRESS Dept. Medicine Francis Scott Key Med Ctr | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 7/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | |
| 24. FUNERAL DIRECTOR WM. C. March F/H Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1986 | | | | | |
| ADDRESS 1101 E. North Ave. | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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DM

00-13885

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| FOR Film G619 item 18,22 1- STATE REGISTRAR 9/15/86 rja | | | | | | | | | |
| R.G. NO. 1-9991 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH F. TEMPLE, Jr. | | | | | | | | | |
| 2. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 7-26-86 | | 26. HOUR | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. IF UNDER 24 HRS. | |
| Male | | White | | May 29, 1944 | | 42 RS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 24 HOUR | |
| Wilm., Delaware | | U. S. A. | | | | Baltimore City | | 2:10a | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Lutheran Hospital | | Laborer - Construction | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS | | | |
| Md. | | Baltimore | | Arbutus | | 4767 Bellwood Green-2122 | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Joseph F. Temple, Sr. | | Alice G. Renshaw | | Yes | | 1962-63 | | Catonsville, Md. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18b. IMMEDIATE CAUSE (a) | | 18c. DUE TO, OR AS A CONSEQUENCE OF | | 18d. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. | | 18e. TIME INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | Narcotism | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | ? P.M. 1/?/86 | | Subject used drugs | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) | | | | | |
| | | Unknown | | unknown | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | |
| Margarita A. Korell | | M.D. Assistant | | 7-26-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | |
| Margarita A. Korell | | 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | | |
| Burial | | 7/29/86 | | Cedar Hill Cemetery | | Glen Burnie, Maryland | | | |
| 24. FUNERAL DIRECTOR (NAME ADDRESS) | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Sterling Funeral Estate, P. A. 736 Edmondson Ave., Baltimore, Md. 21228 | | JUL 30 1986 | | Julia Davidson | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 19942

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Marlene E Thacker | | 2a. DATE OF DEATH MONTH 7 DAY 4 YEAR 86 | | 2b. HOUR 7:00 am | |
| 3. SEX female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 4 YEAR 18 41 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | |
| 12b. KIND OF BUSINESS OR INDUSTRY restaurant | | 13a. STATE MD | | | |
| 13b. COUNTY A.A. | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 105 First Ave. / 21225 | | 14. FATHER'S NAME FIRST William MIDDLE J LAST Bradshaw | | | |
| 15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Fergen LAST Fergen | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. 220 36 1170 | | 17. INFORMANT ADDRESS Vernon C. Thacker (same as 13E) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Probable Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/86 19 86 to 7/4 19 86 , that (I) (we) last saw the deceased alive on 7/4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) use the body after death. | | | | | |
| 22b. SIGNATURE Song Chol Chon | | DEGREE M.D. | | 22c. DATE SIGNED 7/4/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Song Chol Chon | | 22e. ADDRESS 3001 S. Hanover St. Baltimore, MD 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 7/7/86 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven | |
| 23d. LOCATION (CITY OR TOWN) COUNTY Glen Burnie A.A. Md. | | 24. FUNERAL DIRECTOR NAME George J. Gonce ADDRESS 4001 Ritchie Hwy. Baltimore Md. 21225 | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 8 - 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

(P)

Original VHS
2001
James O. Gonne
2001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 9 9 3

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|-------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ANNA | | THOMAS | | 7-17-86 | | 12 15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | B | 3-29-07 | | 79 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| UNKNOWN | USA | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Dukeland Nursing Home | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Md | | | | | | 1517 N. Broadway 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| NO | | 214-74-4514 | | Betty Anderson 423 E. Lafayette Ave | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CAMMIA ARTERIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAMMIA ARTERIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/16/86</u> to <u>7/17/86</u> that (I) (we) lost the deceased alive on <u>7/17/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>[Signature]</u> DEGREE | | 22c. DATE SIGNED <u>7/18/86</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u> | |
| 22e. ADDRESS <u>9037 BALTIMORE CRYSTAL</u> | | 23a. BURIAL, CREMATION, REMOVAL (SP) <u>Burial</u> | | 23b. DATE <u>7-22-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem</u> | |
| 23d. LOCATION <u>Balto. Md.</u> | | 23e. NAME OF FUNERAL DIRECTOR <u>Leroy O. Dyett</u> | | 23f. DATE REC'D BY REGISTRAR <u>JUL 22 1986</u> | | 23g. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

BP
DHMH-16 50M 1-B1
(VRA 15, 4)

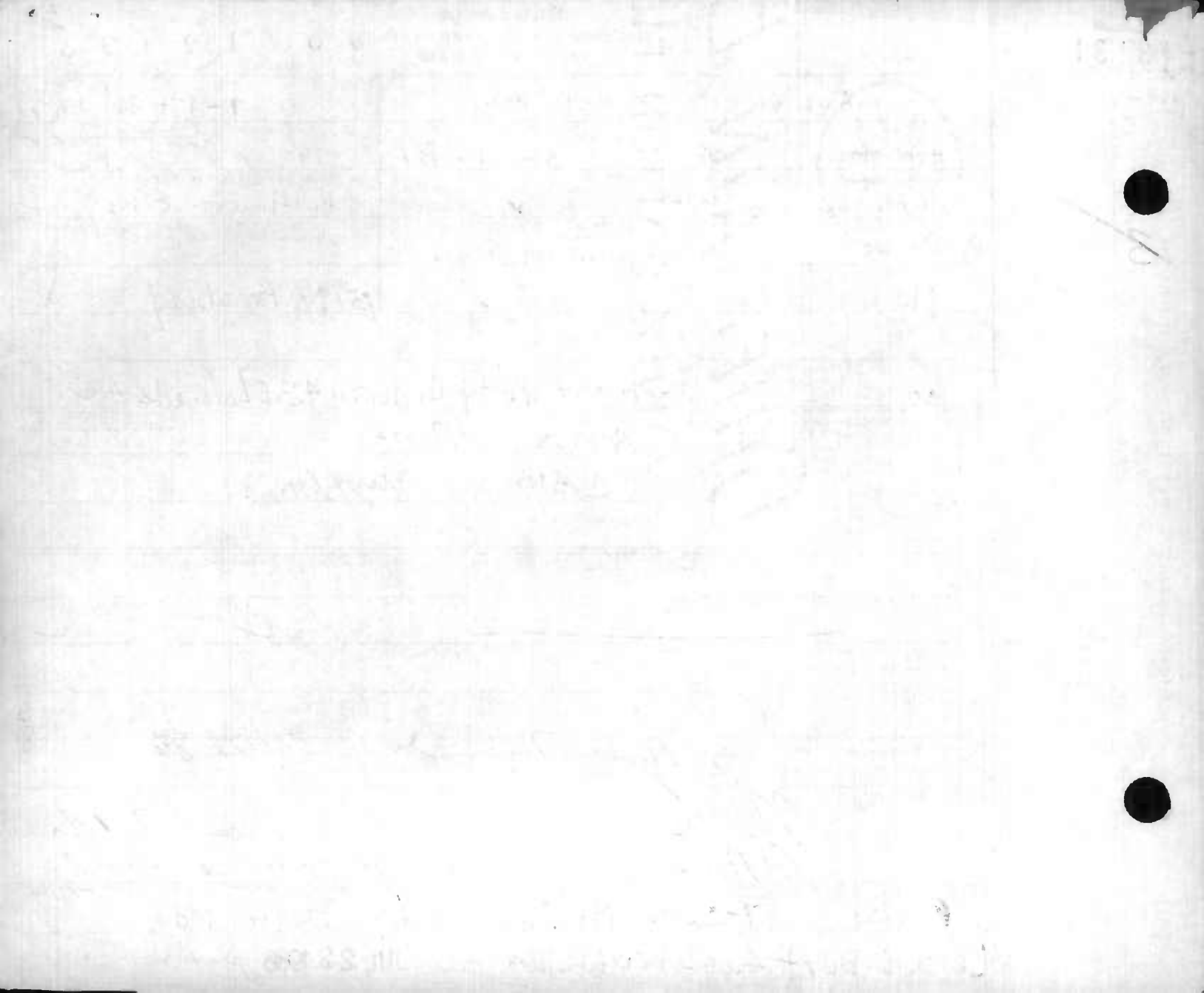
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, it should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Dyett, Leroy O. Home
4600 Liberty Hgts
664-6900



00-12834

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

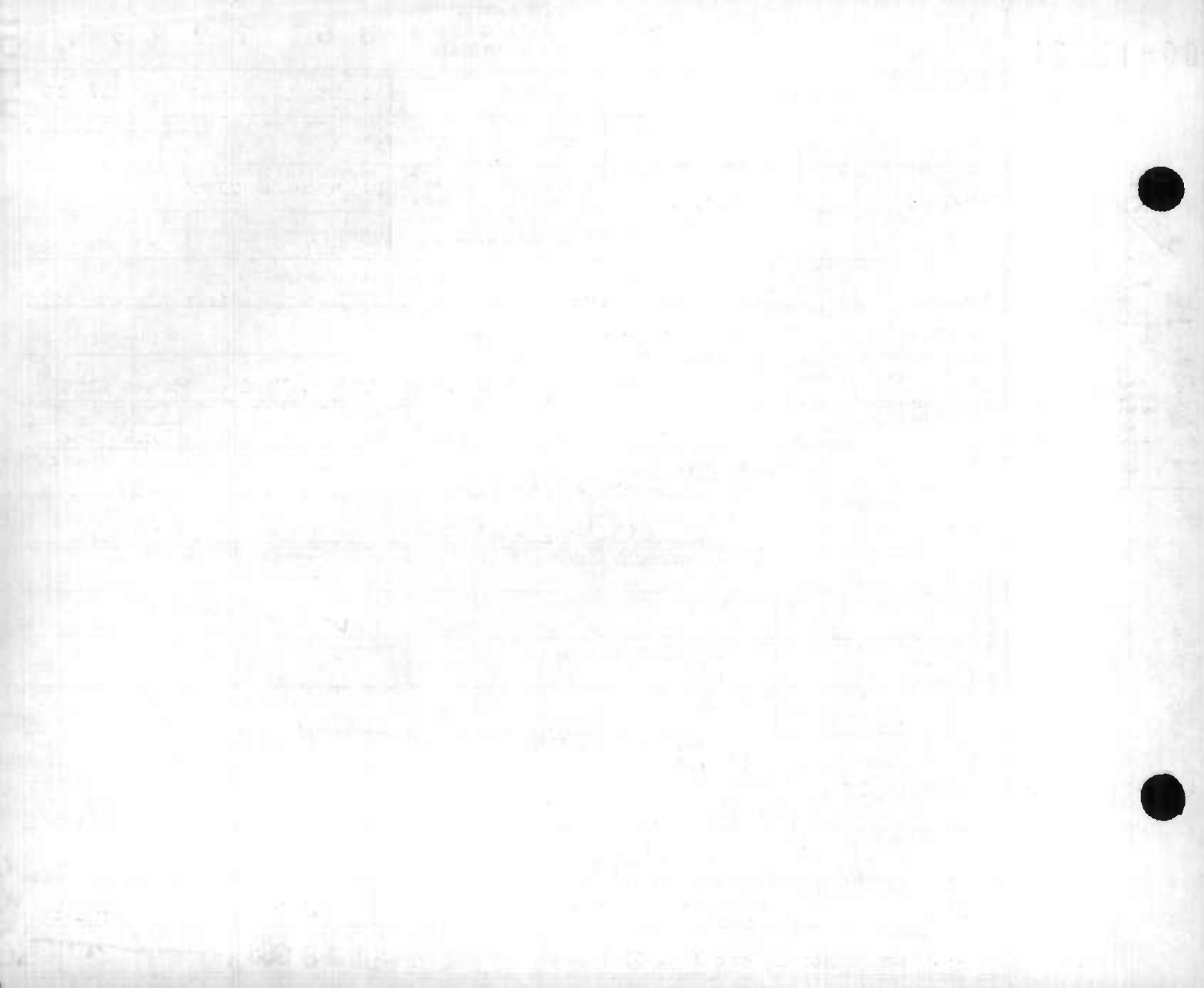
| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST DENISE THOMAS | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1986 | | 2b. HOUR A 11:30 M | |
| 1. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 7 3 61 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 25 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? u.s.a. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Charles | | 15. MOTHER'S MAIDEN NAME Susan Musgrove | | 13e. STREET ADDRESS / ZIP CODE 2325 East Madison Street 21205 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown | | 17. INFORMANT ADDRESS Susan Thomas 2325 E. Madison Street 21205 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>primary osteostoma</u> (c) <u>cerebral edema</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>same day</u> <u>2 yrs</u> <u>1 week</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/11/86</u> , 19 <u>86</u> , to <u>7/16/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/16/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Theodore MacKinney</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/16/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Theodore MacKinney</u> | | 22e. ADDRESS <u>JHH</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March Funeral Home Inc. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 18 1986 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

THOMAS, DENISE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please return the completed pages to the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please return the completed pages to the funeral director. TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-12828

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

19995

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EUNICE THOMAS | | 2a. DATE OF DEATH MONTH JULY DAY 16 YEAR 1986 | | 2b. HOUR 7:00 AM | |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH June DAY 20 YEAR 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OR PRINT, WORKING LIFE) PSYCHIATRIC NURSING ASST. | | 12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Norfleet MIDDLE Everett LAST Isabell | | 15. MOTHER'S MAIDEN NAME FIRST Isabell MIDDLE Carter LAST Carter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. 214-20-9415 | | 17. INFORMANT 3617 N. Rogers Avenue Lowrayn A. Thomas Baltimore, Maryland 21207 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **IRREVERSIBLE CARDIOGENIC SHOCK**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **SEVERE METABOLIC ACIDOSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **MESENTERIC INFARCTION**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **ACUTE RENAL FAILURE**

| | | | |
|--|--|---|--|
| 19a. DATE OF OPERATION 7/14/86 AND 7/15/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED THROMBOSIS OF SURVIVAL MESENTERIC ARTERY BYPASS GRAFT | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14/86 to 7/16/86 ; that (I) (we) last saw the deceased alive on 7/15/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If hospitalized) (did not) (saw) the body after death. | | | |
| 22b. SIGNATURE GARTH ASSAMUELS (THE PHYSICIAN'S NAME (TYPE OR PRINT)) | | 22c. DATE SIGNED JUL 18 1986 | |
| 22d. ADDRESS 6911 PARK HEIGHTS AVE, BALTIMORE MD 21215 | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |

| | | | |
|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/20/1986 | 23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Pk. | 23d. LOCATION CITY OR TOWN Laurel, COUNTY Maryland STATE Md. |
| 24. FUNERAL DIRECTOR NAME NUTTER & SONS FUNERAL HOME, INC. ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

CHIEF WINTER

1875

1875

00-12358

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2 (REMAIN PAGE 4 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19996

| | | | | | | | | | | | | | | | |
|--|--|------------------|--|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judy Lynn Thomas | | | | | | | | | | ESTIMATED MONTH DAY YEAR 7 13 1986 | | M 11:30 P | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 12 65 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 20 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 13 1986 | | 2d. HOUR 11:30 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietitian | | | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD Carroll Sykesville | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 7345 Gaither Road 21784 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles V. Rhinehart | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruthanne Pickett | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. ? | | | | 17. INFORMANT ADDRESS Ruthanne Thomas Sykesville, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR:MIN:MONTH DAY YEAR 8 P.M. 7 13 1986 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in truck/fixed object impact | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 99 north of Marriottsville Rd, Howard Co, MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 7/14/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. ZANE, M.D. | | | | ADDRESS 111 Penn St. Balto. MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-17-86 | | | | 23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD | | | |
| 24. FUNERAL DIRECTOR NAME Haight Funeral Home | | | | ADDRESS Sykesville, MD | | | | 25a. DATE REC'D BY REGISTRAR JUL 14 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

07/B4
25M

BP _____
DHMH - 17
(VR A15 ME (5))

RECEIVED 10-10-71

WINTER



00-14036

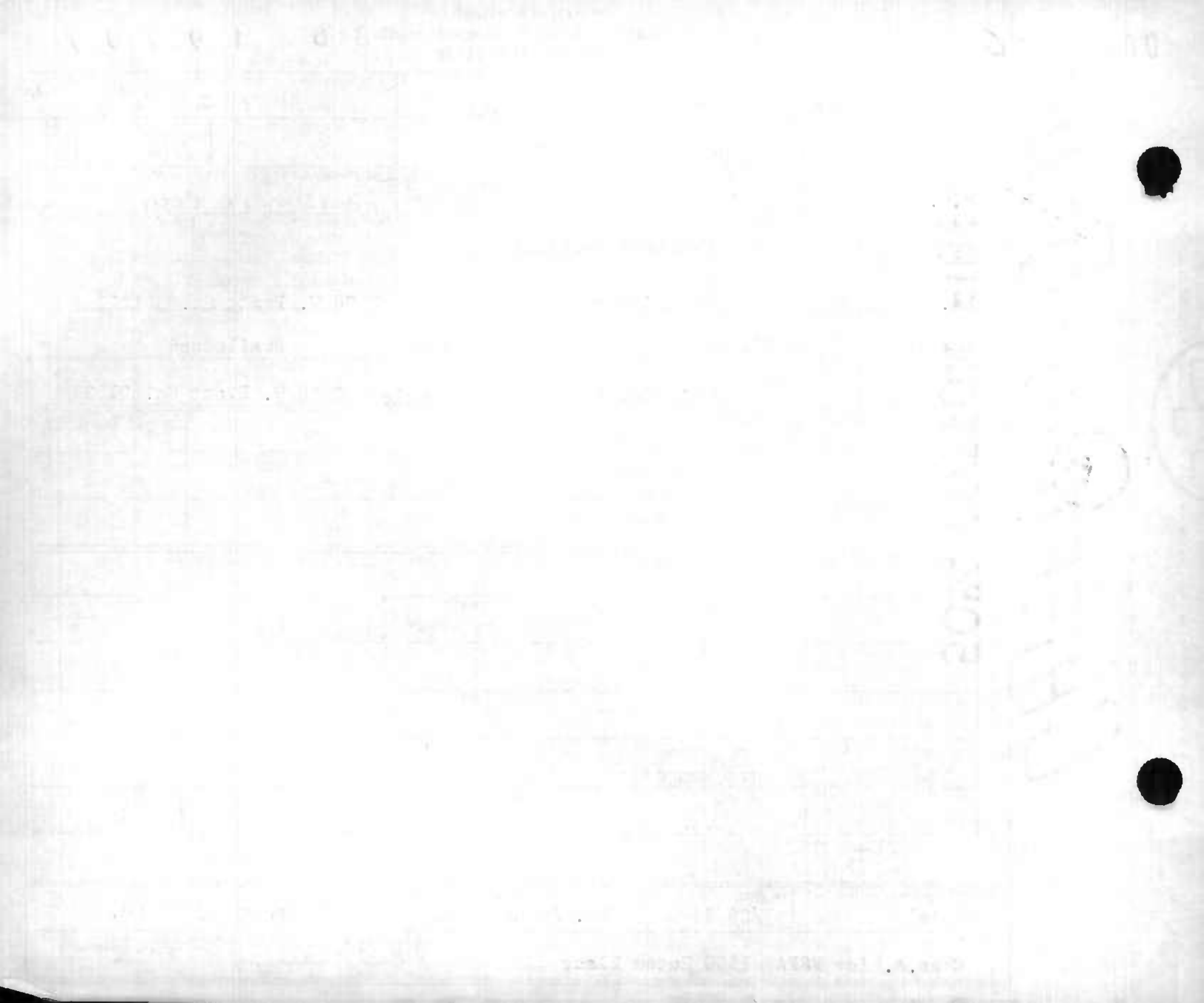
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 9 9 9 7

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY | | FIRST - | | MIDDLE - | | LAST Thomas | | 2a. DATE OF DEATH MONTH 7 DAY 23 YEAR 86 | | 2b. HOUR 6:30 AM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 3 DAY 22 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS 7 DAYS 23 | | IF UNDER 24 HRS HOURS 6 MIN. 30 | |
| 7a. BIRTHPLACE (COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2528 W. Pratt St. 21223 | | | |
| 14. FATHER'S NAME FIRST James MIDDLE Brailsford LAST - | | | | 15. MOTHER'S MAIDEN NAME FIRST Jo Anna MIDDLE Brailsford LAST - | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-34-7103 | | 17. INFORMANT ADDRESS Arthur Butler 2528 W. Pratt St. 21223 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Breast Cancer | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 year | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET 86 | | CITY OR TOWN Westport | | COUNTY Md. | | STATE Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 86 , to 7/22 , 19 86 , that (I) (we) last saw the deceased alive on 7/23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Philip Kanto | | | | DEGREE Philip Kanto | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Kanto | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem, | | 23d. LOCATION CITY OR TOWN Westport | | COUNTY Md. | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Chas.A.Rice FSPA 1300 Eutaw Place | | | | | | 25a. DATE RECD. BY REGISTRAR JUL 31 1986 | | 25b. REGISTRAR'S SIGNATURE Richard A. Riddle | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-12416

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT THOMAS | | | 2a. DATE OF DEATH MONTH DAY YEAR July 9, 86 | | 2b. HOUR 8:25 P.M. |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 11 10 09 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norfolk, VA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | |
| 10. CITY OR TOWN OF DEATH BALT | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | 13b. COUNTY BALT | 13c. CITY OR TOWN BALT | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1501 N. Rutland St., # 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-12-4007 | | 17. INFORMANT ADDRESS Velmer Napier 1914 McCulloh St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. arrest DUE TO, OR AS A CONSEQUENCE OF (b) Long Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dehydration; Decubitus Ulcer | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 9, 1986 to July 9, 1986 , that (I) (we) last saw the deceased alive on July 9, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Andrew Weinstein MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Weinstein | | | | 22e. ADDRESS 6605 Copper Ridge Rd. Balt., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-19-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion | |
| 23d. LOCATION Balto. COUNTY STATE MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS Wm C. Brown Comm. F.H. 1206 W. North Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Their phone remove carbon papers, pages 1 and 2 should be filed within 72 hours after death.

BP

7

1

0-14151

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Curtis

B.

Thompson Jr.

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR

2b. HOUR

7/ 31/ 86

M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

2

25

64

6. AGE (IN YEARS)

22

YRS.

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7c. DATE PRONOUNCED DEAD

7/ 31/ 86

2d. HOUR

3:10

A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

UNEMPLOYED

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1839 E. Chase Street 21213

14. FATHER'S NAME

Curtis

MIDDLE

LAST

Thompson

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

Dye

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN) NO

16b. SOCIAL SECURITY NO.

216-78-3387

17. INFORMANT

ADDRESS

Mary Thompson 1839 E. Chase Street

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 7/31/86

EXAMINER'S NAME (TYPE OR PRINT)

Gregory R. Kauffman, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

8/4/86

23c. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

23d. LOCATION

CITY OR TOWN

Baltimore,

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

March Funeral Homes 1101 East North Avenue

25a. DATE REC'D. BY REGISTRAR

AUG 1 1986

25b. REGISTRAR'S SIGNATURE

RECEIVED

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

1911-12



1911-12

00-13802

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #3 and #4 and return them to the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. 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Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

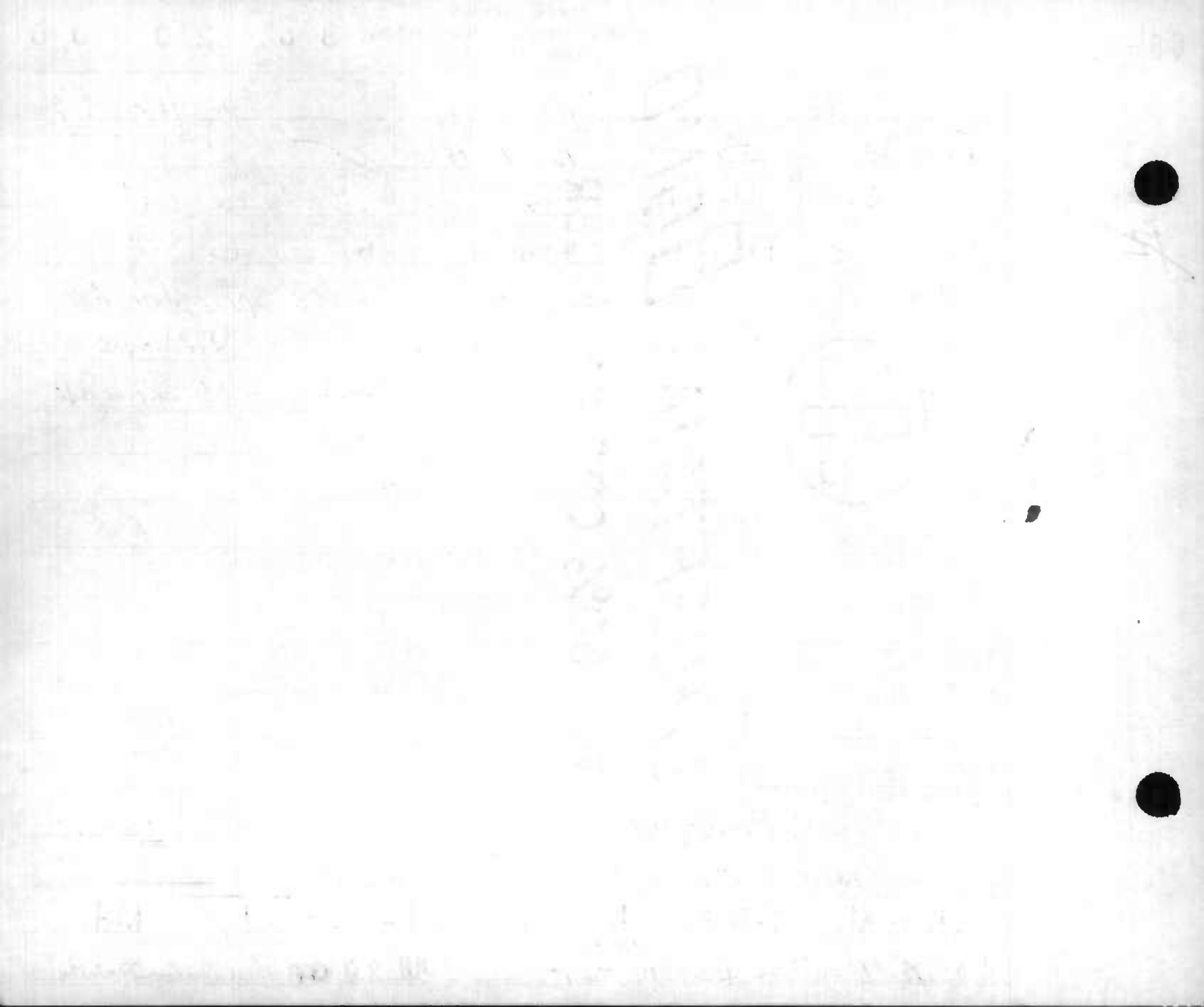
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 0 0

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lila Thompson</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7/27/86</i> | | 2b. HOUR <i>4:38</i> M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12 1 1920</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>65</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Balto</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE <i>4008 Springdale Ave. 21201</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Joe Perkins</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Gina Williams</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>249-38-8591</i> | |
| 17. INFORMANT ADDRESS <i>Mrs. Gussie Martin 4008 Springdale</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i></i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/27</i> 19 <i>86</i> , to <i>7/27</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>7/27</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Eleanor Y. Hixon, MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>7/27/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eleanor Y. Hixon, MD</i> | | 22e. ADDRESS <i>2600 Liberty Rd.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7-31-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Md. National Mem</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel Md.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Jos A. Montan + sons F. H.</i> | | ADDRESS <i>1701 Laurens</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 29 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | |

BP



00-12931

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

20001

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA EMMA THOMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-8-86 | | 2b. HOUR 5:15 P M |
| 3. SEX FEMALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE VIRGINIA | | 13c. CITY OR TOWN Westmoreland KINSALE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE RT. 1, Box 254 22488 |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER THOMPSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA JOHNSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. 230-364608 | | 17. INFORMANT Betty L. Hardy | | ADDRESS BALTIMORE MD. 106 SUMMER COURT | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melastatic Carcinoma - Cachexia DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Colon - DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30, 19 86, to 7/8, 19 86, that (I) (we) lost saw the deceased alive on 7/8, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Blut T Duong | | DEGREE M.D. | | 22c. DATE SIGNED 7-8-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLUT T DUONG | | 22e. ADDRESS LUTHERAN HOSPITAL - | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/12/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Zion BAPT. CHURCH KINSALE | |
| 23d. LOCATION COUNTY STATE VIRGINIA | | 24. FUNERAL DIRECTOR NAME Hanville E. Fisher | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 15 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP _____

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|-----------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) NATHANIEL THORNTON Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 17 86 | | 2b. HOUR 8:46 P.M. | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 06 29 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1436 N. Broadway 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Thornton, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Thomas | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OF UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-38-2492 | | 17. INFORMANT ADDRESS Ann Thornton 1436 N. Broadway | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) cerebral edema | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) metastatic cancer to brain, epithelial origin | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) probable lung cancer | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 19 85, to 7/17 19 86 that (I) (we) last saw the deceased alive on 7/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lalah Newbrough MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lalah Newbrough | | | | 22e. ADDRESS 1 S. Calvert St. Balto, Md. 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 7/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

MEDICAL CERTIFICATION

00-11708

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 0 0 0 3
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NANNIE B Threat | | 2a. DATE OF DEATH MONTH DAY YEAR 07 04 86 | | 2b. HOUR 230 | |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 08 14 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rockboro NC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L Deaton | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE 710 Wharton Court 21205 | |
| 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Brooks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Riva Claire | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-01-1088 | | 17. INFORMANT Jeanette Brown | |
| | | | | ADDRESS 710 Wharton Court | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A NOREXIA DUE TO, OR AS A CONSEQUENCE OF (b) ABDOMINAL CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (c) unknown | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 30 19 86 , to JULY 4 19 86 , that (I) (we) last saw the deceased alive on JULY 3 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Edward G Richman MD | | DEGREE MD | | 22c. DATE SIGNED 7-4-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD G RICHMAN | | 22e. ADDRESS 611 S. Charles St. Baltimore MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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00-11854

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20004

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL TOM PAKOV | | 2a. DATE OF DEATH MONTH DAY YEAR July 5 1986 | | 2b. HOUR 05 12 A.M. | |
| SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 20 1916 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 70 YRS. | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) BOSTON, MA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KEVINAVE HEBREW GOLIATHIC CENTER + HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Translator-Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY EDUCATION |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) NEW YORK STATE QUEENS | | 13c. CITY OR TOWN BROOKLYN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13. STREET ADDRESS / ZIP CODE 1428 E. 5th St. Apt. 2C Bklyn, NY 11230 |
| FATHER'S NAME MAX TOMPAKOV | | 15. MOTHER'S MAIDEN NAME REBECCA SACKS | | | |
| 6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII -ARMY | 17. INFORMANT ADDRESS (21208) SYLVAN TOMPAKOV 31 FARMHOUSE CT. BALTO. MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLONIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I (this hospital) attended the deceased from 6/26, 19 86, to 7/5, 19 86, that (we) lost saw the deceased alive on 7/5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE ESTRELVITA O. KUN, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 7/5/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS KEVINAVE HEBREW GOLIATHIC CENTER + HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | 23b. DATE 7/6/86 | 23c. NAME OF CEMETERY OR CREMATORY OHEL YAAKOV CONG. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1986 | | | |

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DIVISION OF VITAL RECORDS
(VIA 15-4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed and filed in the funeral director's office within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove copies of this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

[illegible][illegible]

0-13753

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


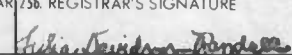
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

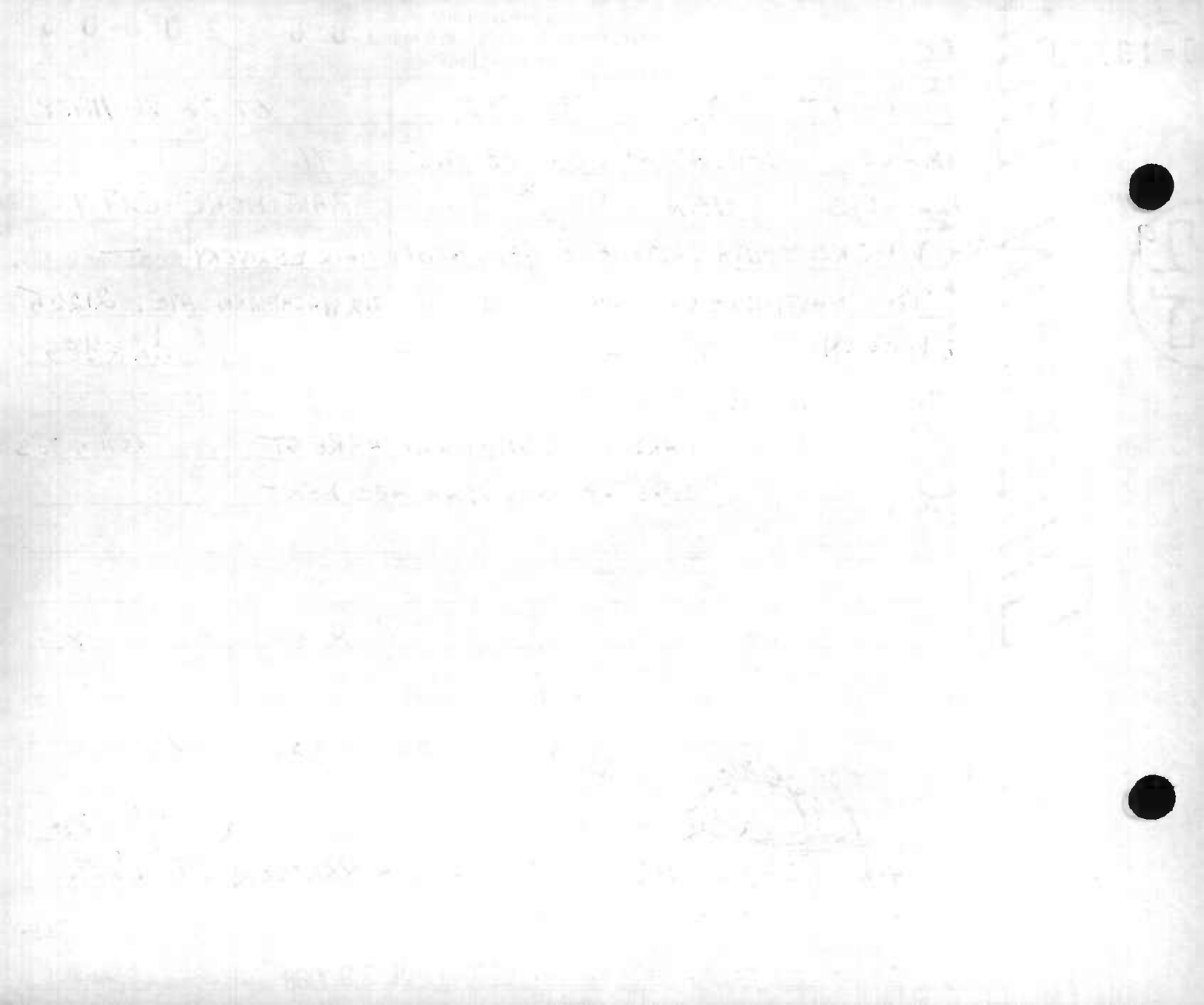
1- FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 6 2 0 0 0 5

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT D. TONTZ | | | 2a. DATE OF DEATH MONTH 07 DAY 26 YEAR 86 | | | 2b. HOUR 7:43 P.M. | | | |
| 3 SEX MALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH MONTH 06 DAY 03 YEAR 1915 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS 00 DAYS 00 HOURS 00 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP. | | | | 12a. USUAL OCCUPATION (IF OCCUPATION) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Seal Test Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 212 WASHBURN AVE, 21225 | | | | |
| 14. FATHER'S NAME FIRST LOGAN MIDDLE TONTZ LAST TONTZ | | | 15. MOTHER'S MAIDEN NAME FIRST AURA MIDDLE HUGHES LAST HUGHES | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. WW II 315-10-4203 | | 17. INFORMANT ADDRESS SADIE TONTZ (WIFE) SAME ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 MINUTES | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR: A.M. MONTH: DAY: YEAR: P.M. 19 | | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7/1/86 to 7/26/86 , that (2) (we) last saw the deceased alive on 7/26/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) did not cause the death. | | | | | | | | | |
| 22b. SIGNATURE  | | | | | DEGREE | | 22c. DATE SIGNED 7/27/86 | | |
| 22d. PHYSICIAN'S NAME A.H. KLEIN MD | | | | | 22e. ADDRESS 3001 SOUTH HANOVER ST, BALT. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | 23d. LOCATION OWINGS MILLS, COUNTY STATE MD. | | |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1986 | | 25b. REGISTRAR'S SIGNATURE  | | |

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00-11601

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 2 0 0 0 6

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST Henderson | | | | MIDDLE Torrence | | | | LAST Torrence | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 3. SEX M | | | | 4. RACE B | | | | 5. DATE OF BIRTH MONTH DAY YEAR 1 15 1900 | | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 86 YRS. | | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 5/ 1986 | | | | 2d. HOUR 12:55 a M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE MD | | | | 13b. COUNTY BALTIMORE | | | | 13c. CITY OR TOWN BALTIMORE | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 1412 CHESAPEAKE CT | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR TORRENCE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | | | 16b. SOCIAL SECURITY NO. 212-18-5431 | | | | 17. INFORMANT ADDRESS MARRIE JONES 1412 CHESAPEAKE CT | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 7/5/86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-11-86 | | | | 23c. NAME OF CEMETERY OR CREMATORY Mt Zion | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD, MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Marshall Adams | | | | ADDRESS 638 N 9th St | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN EACH OF THE SPACES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT RECORD. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on page 1, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8620007 | |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK L. TOWNSEND | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-23-86 | | | 2b. HOUR 6:07am | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 5-26-1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 yrs. YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS) (LIFE) Engineer Stationary | | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3215 Brendan Avenue 21213 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Dale Townsend | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Blanks | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 212-14-1096 | | 17 INFORMANT ADDRESS 21213 Josephine Croucher 3059 Mayfield Ave | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1-9</u> , 19 <u>86</u> , to <u>7-23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Carla Wolf Rosenthal</u> | | | | DEGREE <u>M.O.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>7-24-1986</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Carla Rosenthal | | | | | | 22e. ADDRESS Brehms Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 25 1986 | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | | | |

RECEIVED
COLLIERIES



00-12231

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 0 8

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elsie TRAPP | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 10 86 | | | 2b. HOUR 2:05a.m. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 10 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 2:05a.m. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE CITY | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BELAIR CONVALESCARIUM | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 15. KIND OF BUSINESS OR INDUSTRY - | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland | | | 12b. COUNTY Baltimore | | 12c. CITY OR TOWN Cockeysville | | 13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Edward Schuhart | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Long | | | 16. STREET ADDRESS / ZIP CODE 10419 Greentop Rd., 21030 | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 18. SOCIAL SECURITY NO. 214-20-5036 | | 19. INFORMANT ADDRESS Sharon A. Trapp, 10419 Greentop Rd., 21030 | | | | | |
| 20. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA - | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD ASUD | | | | | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a | | | | | | | | | |
| 21a. DATE OF OPERATION | | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL TREATMENT) | | | 21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-16-82 , 19 82 , to 7-10 , 19 86 , that (I) (we) last saw the deceased alive on 6-20 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE Lawrence Boas MD | | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Boas MD | | | 22c. ADDRESS 50 Scott ADAM RD. Cockeysville MD 21030 | | 22d. DATE SIGNED 7/10/86 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/12/86 | | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Evangelical | | 23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix Balto. Md. | |
| 24. FUNERAL DIRECTOR (NAME) Bryan W. Clary, 10 W. Padonia Rd., 21093 | | | 25. DATE REC'D. BY REGISTRAR JUL 14 1986 | | | 26. REGISTRAR'S SIGNATURE John Davidson | | | |

June 19 1941

File

J. A.

W. L. L.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 20009

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | |
| Frank Trezise | | | 7 | | | 10 | | | 86 | | | 8 35 P. | | | M. | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. UNDER 1 YEAR | | | 8. UNDER 24 HRS. | | |
| male | | | Caucasian | | | 7 02 02 | | | 84 | | | YRS. | | | MONTHS | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 10. CITIZEN OF WHAT COUNTRY? | | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 12. BALTIMORE CITY OR COUNTY OF DEATH | | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 14. KIND OF BUSINESS OR INDUSTRY | | |
| Md. | | | Fed. U.S. | | | | | | Baltimore City MD. | | | | | | | | |
| 15. CITY OR TOWN OF DEATH | | | 16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 18. STATE | | | 19. CITY OR TOWN | | | 20. INSIDE CITY LIMITS? | | |
| Balto. | | | Federal Hill Nrsng Ctr | | | | | | Md. | | | BALTO | | | BALTO | | |
| 21. FATHER'S NAME | | | 22. MOTHER'S MAIDEN NAME | | | 23. STREET ADDRESS / ZIP CODE | | | 24. DATE OF OPERATION | | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26. AUTOPSY? | | |
| 1268 Sargent St. 21223 | | | 1268 Sargent St. Balto., Md. 21223 | | | 1268 Sargent St. 21223 | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 15b. SOCIAL SECURITY NO. | | | 16. INFORMANT | | | 17. ADDRESS | | | 18. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | 19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| Yes | | | 216-07-1019 | | | Ms. Gloria Fink | | | Balto., Md. 21223 | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE Many years. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA, Arterial HTN | | | | | | | | | | | | | | | | | |
| 20a. DATE OF OPERATION | | | 21b. TIME OF INJURY | | | 22c. HOW INJURY OCCURRED | | | 23a. PLACE OF INJURY | | | 24a. LOCATION | | | 25a. DATE SIGNED | | |
| 1986-10-07 | | | 4-25-1986 | | | to 7-10-1986 | | | that (I) (we) last saw the deceased alive on 7-10-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE | | | 22c. DATE SIGNED | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 22c. HOW INJURY OCCURRED | | | 23a. PLACE OF INJURY | | | 24a. LOCATION | | | 25a. DATE SIGNED | | |
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 20010 | |
|--|--|--|--|---|--|---|--|---|--|----------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE B. TRIBULL | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1986 | | | 2b. HOUR 10:45AM | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 5 2 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Furn. Finisher-Bagby Furn. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5604 Anthony Ave. 21206 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman P. Tribull | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 212-09-5346 | | 17. INFORMANT Anna May Tribull | | | | ADDRESS 5604 Anthony Ave. 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA REPLACING MUCH OF LIVER DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE PULMONARY PRIMARY TUMOR DUE TO, OR AS A CONSEQUENCE OF (c) St. Thy No Pathologist APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/5/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED POSSIBLE LIVER TUMOR | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED - | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1, 1986 to JULY 9, 1986 , that (I) (we) lost saw the deceased alive on JULY 9, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE X H. J. Miller | | DEGREE MURARI BIJPURIA M. D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-9-86 | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| MURARI BIJPURIA M. D. | | | | CHURCH HOSPITAL CORP. 100 NORTH BROADWAY BALTO. MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-12-86 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc. 6415 Belair Rd. 21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1986 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall | | | |

00-12658

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 0 0 1 1

| | | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELEANORE V TRUITT | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 86 | | 2b. HOUR 11:50 AM | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 0-1 16 18 68 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John T. Freeland | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Coates | | | 13e. STREET ADDRESS / ZIP CODE 712 Appleton St 21212 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-0606 | | 17. INFORMANT Milton Truitt | | ADDRESS 712 N. Appleton St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Breast Ca DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14, 19 86 to July 14, 19 86 that (I) (we) last saw the deceased alive on July 14, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Andrew Weinstein, MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/14/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Weinstein, MD | | | | 22e. ADDRESS 6605 Copper Ridge Dr Balt, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md. | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H West | | | | ADDRESS 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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00-13022

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charlie | | FIRST TUCK | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR July 15, 1986 | | 7b. HOUR 10:25 A M | |
| 3 SEX MALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 08-23-07 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1102 DRUID HILL AVENUE 21201 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PETER TUCK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DONA GRANT | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-2799 | | 17. INFORMANT ADDRESS LETTIE TUCK 1102 DRUID HILL AVE. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Right upper lobe pneumonia; Bilateral cerebrovascular accident. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 14 , 19 86 , to July 15 , 19 86 , that (1) (we) last saw the deceased alive on July 15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do) view the body after death. | | | | | | | | | | | |
| 27b. SIGNATURE Jyotin Parikh M.D. | | | | DEGREE | | | | 27c. DATE SIGNED 7/15/86 | | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) Jyotin Parikh, M.D. | | | | 27e. ADDRESS c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-19-86 | | 23c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS BROWN/THOMPSON F.H. 1913 W. BALTIMORE ST. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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CHINA



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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from this certificate. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic injury, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 6 2 0 0 1 3 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH TUCKER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/2/86 7/2/86 | | 2b. HOUR 824 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 18 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCES SCOTT KEY MCO CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSPECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL TUCKER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH FREEMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 567-10-9997 | | 17. INFORMANT ADDRESS MR. LOUIS TUCKER APT. 1A 7 COBBLESTONE CT. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) NONE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/86 to 7/2/86 , that (I) (we) last saw the deceased alive on 7/2/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alan P. Marco MD | | | | DEGREE MD | | 22c. DATE SIGNED 7/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN P MARCO | | | | 22e. ADDRESS 4940 EASTERN AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 4, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD | | | | 25a. DATE REC'D BY REGISTRAR JUL 25 9 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY HRS MIN. | |
| FIRST MIDDLE LAST | | July 22 1986 | | 1445 M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | |
| Male | | White | | MONTH DAY YEAR | |
| | | | | August 14, 1903 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Maryland | | USA | | 82 | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | BALTIMORE CITY MD. | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | |
| Maryland | | | | Baltimore | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 13d INSIDE CITY LIMITS? | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| George Tuckey | | Mary Peacock | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | |
| No | | 216-44-3431 | | 1245 Linkside Drive Baltimore, Md. 21234 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>COPD</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>CHF</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>July 19</u> , 19 <u>86</u> , to <u>July 22</u> , 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>July 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| <u>S. O. TERRATOLA MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/22/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| S. O. TERRATOLA MD | | 201 UNIVERSITY PKWY | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | |
| Burial | | July 25, 1986 | | Woodlawn | |
| 24 FUNERAL DIRECTOR | | 23d LOCATION CITY OR TOWN COUNTY STATE | | 23e DATE REC'D. BY REGISTRAR | |
| JAMES Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md. 21212 | | Woodlawn, Balto. Co., Md. | | 7-2 JUL 24 1986 | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | <u>[Signature]</u> | | | |

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20015

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward A. Tugwell | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 09 86 | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 12 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2049 Druid Park Drive 21211 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 2049 Druid Park Drive 21211 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Adoniran Tugwell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 213-10-2883 | | 17. INFORMANT ADDRESS 21211 Shirley W. Kleeman 2049 Druid Park Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>subtle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>subtle</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subtle</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Diabetes, Carcinoma of Larynx, Old CVA</u> | | | | | | | |
| 19a. DATE OF OPERATION -- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -- | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. -- 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -- | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -- | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE -- -- -- | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>85</u> , to <u>7/9</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/10</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Robert T. Levy</u> | | | | DEGREE -- | | 22c. DATE SIGNED <u>7/10/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert T. Levy</u> | | | | 22e. ADDRESS <u>114 Medical Art Bldg</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR 7-15-86 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the report. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodide in aqueous solution. The organization of the report is as follows: Introduction, Experimental, Results, Discussion, and Conclusion.

2. The second part of the report is the experimental section. It describes the apparatus and the procedure used in the experiment. The apparatus consists of a reaction flask, a thermometer, and a stopper. The procedure is as follows: A known volume of hydrogen peroxide solution is added to a known volume of potassium iodide solution in the reaction flask. The temperature of the mixture is measured. The reaction is started by adding a small amount of potassium iodide solution. The time taken for the reaction to complete is measured. The rate of reaction is calculated from the time taken for the reaction to complete.

3. The third part of the report is the results section. It presents the data obtained from the experiment. The data are as follows:

| Temperature (°C) | Time taken for reaction to complete (s) |
|------------------|---|
| 10 | 120 |
| 20 | 60 |
| 30 | 30 |
| 40 | 15 |

4. The fourth part of the report is the discussion section. It discusses the results of the experiment and compares them with the theoretical results. The results show that the rate of reaction increases with increasing temperature. This is in agreement with the theoretical results, which predict that the rate of reaction increases with increasing temperature. The activation energy of the reaction is determined to be 50 kJ/mol.

5. The fifth part of the report is the conclusion section. It summarizes the findings of the experiment and states the conclusions. The conclusions are that the rate of reaction increases with increasing temperature and that the activation energy of the reaction is 50 kJ/mol.



00-12168

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20016

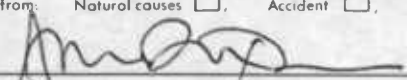
1. FOR
STATE
REGISTRAR


| | | | | | | | | | |
|---|---------------------|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BILLY | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 7 1986 | | | | 2b. HOUR M 11:55 PM | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 7 17 59 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 26 YRS. | IF UNDER 1 YR. MONTHS DAYS 7 7 | | IF UNDER 24 HRS. HOURS MIN. 11:55 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 7 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.s.a. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stand Ball | | 12b. KIND OF BUSINESS OR INDUSTRY Fuse Co. | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 21231 220 North Chester Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Billy R. Turnage Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Gorham | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 220-68-2662 | | 17. INFORMANT ADDRESS Ruby Turnage 220 N. Chester Street | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 10 P.M. 7-7-1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed. | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 725 Newington Ave., Balto. MD | |

| | | | | | |
|--|--|---|--|---------------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 7-8-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-12-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm.C. March F/H Inc. 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE  | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAYS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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FBI
NEW YORK

00-13742

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 750.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Annie B. Turner | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7/ 23/19 86 | | 2b. HOUR M P |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 7 - 3 - 1910 | 6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS. | 7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Beason, West Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7c. DATE PRONOUNCED DEAD 7/ 23/19 86 | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1601 Joplin St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore City |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1601 Joplin Street 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hiram L. Lovell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Althea A. (Not known) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-34-6167 | | 17. INFORMANT ADDRESS Russell E. Mills 6509 Cleveland Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 7/24/86 |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | ADDRESS 111 Penn St. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 28, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill |
| 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh (Balto. Co.) MD | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Av. Baltimore, Maryland 21222 | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1986 | | 25b. REGISTRAR'S SIGNATURE |



00-13068

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20010

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Stella | | | 2a. DATE OF DEATH MONTH 7 DAY 19 YEAR 86 | | | 2b. HOUR 7⁵⁵ P.M. | | | | | | |
| 3 SEX F | | 4 RACE W | | 5. DATE OF BIRTH MONTH 10 DAY 04 YEAR 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Balt City MD | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD | | 13b. CITY OR TOWN Balt City | | 13c. CITY OR TOWN Balt City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 730 S. Conkling Ave 21231 | | | | |
| 14. FATHER'S NAME FIRST Michael MIDDLE LAST Dzielak | | | 15. MOTHER'S MAIDEN NAME FIRST Rosalie MIDDLE LAST Pazik | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO 370 208336 | | | 17. INFORMANT Walter Tuszynski | | | ADDRESS 730 S. Conkling St. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Atherosclerotic Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Dennis Kurgansky MD | | | | | | DEGREE | | 22c. DATE SIGNED 7-19-86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Kurgansky MD | | | | | | 22e. ADDRESS 301 St Paul Place Balto MD 21203 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-23-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | | |
| 24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc. ADDRESS 401 S. Chester St. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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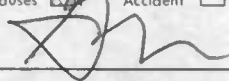

CHIEF CLERK



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1-
FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST Yoshihiro MIDDLE Uchida LAST Uchida | | 2a DATE KNOWN OF DEATH | | X MONTH DAY YEAR | | 2b HOUR | |
| 3 SEX Male | | 4 RACE Japanese | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1941 | | 6 AGE (IN YEARS) LAST BIRTHDAY YRS. 44 | | 7c DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 17/19 86 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Japan | | 7b CITIZEN OF WHAT COUNTRY? Japan | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Scientist | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Maryland | | 13b COUNTY City | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Sukeyoshi Uchida | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kosugi Uchida | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | | |
| 16b SOCIAL SECURITY NO. 216-11-2253 | | 17 INFORMANT ADDRESS Masako Uchida, Same As #13e 21209 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Idopathic myocarditis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7/17/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE 7-21-86 | | 23c NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | 25a DATE REC'D. BY REGISTRAR 4 JUL 22 1986 | | | | | |
| | | | | 25b REGISTRAR'S SIGNATURE  | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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NOV 19 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

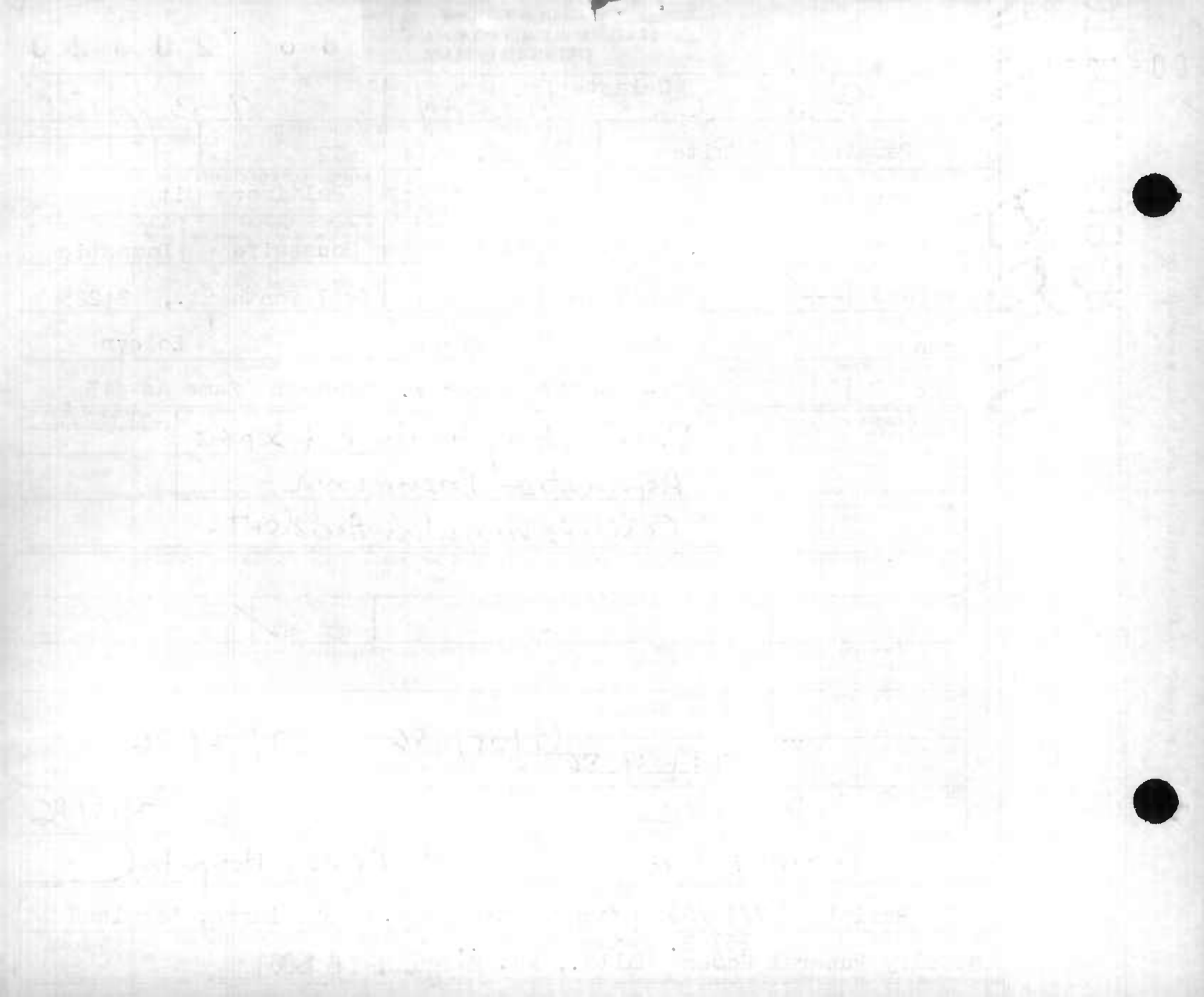
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 6 2 0 0 2 0 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST GRACE C Celeste UPPERMAN | | 2a. DATE OF DEATH | | MONTH DAY YEAR 7 13 86 | | 2b. HOUR 1730 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 27, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife. | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | | | |
| 13a. STATE Maryland | | 13b. COUNTY --- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3817 Tenth St., 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Warner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Boleyn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-8347 | | 17. INFORMANT James V. Upperman | | ADDRESS Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure + Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/12/86</u> to <u>7/13/86</u> , that (I) (we) lost saw the deceased alive on <u>7/13/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Jimmy Sue</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/13/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JIMMY SUE | | 22e. ADDRESS St. Agnes Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Homes | | 237 E. Patapsco Ave. BALTO., Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1986 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION



00-11945

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20021

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) V. BLANCHE VANDECASTLE | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/8/86 | | 2b. HOUR 1258 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10 24 20 | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (COUNTRY) Balto., MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assoc. Campus Minister | | |
| 12b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 13b. COUNTY | 13c. CITY OR TOWN Balto. City | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3400 Cedardale Rd. 21215 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leonard J. Lubbehusen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Schoenlein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 214-12-0221 | | 17. INFORMANT ADDRESS Virginia Cohen, 3400 Cedardale Rd. 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Ca DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/7/86 to 7/8/86, that (I) (we) last saw the deceased alive on 7/7 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Frank L. Hargansky MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-8-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Hargansky MD | | 22e. ADDRESS Mercy Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 7-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 23d. LOCATION BALTO. CITY OR TOWN | | 23e. STATE Balto., MD | | | |
| 24. FUNERAL DIRECTOR John E. Miller, Inc., 6415 Belair Rd. 21206 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

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10095



00-11320

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the funeral director's office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MILDRED A VAUGHAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-1-86 | | | 2b. HOUR 12:20 AM | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 6 25 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | 13b. COUNTY USA | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3708 CALLAWAY AVE. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT CONAWAY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HARCUM | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-4780 | | 17. INFORMANT ADDRESS REV. ALFRED C.D. VAUGHN 3708 CALLAWAY 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-30 , 19 86 , to 7-1 , 19 86 , that (I) last saw the deceased alive on 7-1 , 19 86 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) am (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Rosita R. Cruz M.D. | | | | | | | | 22c. DATE SIGNED 7/1/86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rosita R. CRUZ | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-5-86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. M.D. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS REDD FUNERAL HOME 5209 YORK RD. 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR 12 JUL 2 - 1986 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 2 3

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) Bertha W. Veach | | | 2a DATE OF DEATH MONTH DAY YEAR July 26, 1986 | | 2b HOUR 9A M |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR July 16, 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2601 Gibbons Avenue | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE Maryland | | 13b COUNTY | 13c CITY OR TOWN Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 2601 Gibbons Ave. 21214 |
| 14 FATHER'S NAME FIRST MIDDLE LAST William E. Veach | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Wallace | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-46-2812 | | 17 INFORMANT ADDRESS William V. Veach Rt.1 Box 98 Airville, Penna. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (the hospital) attended the deceased from 5/1 19 72 to 7/26 19 86 , that (I) (we) last saw the deceased alive on 6/17 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (we) (we) the body after death. | | | | | |
| 22b SIGNATURE J. Rollin DEGREE M.D. | | | | 22c DATE SIGNED 7/28/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Roland A. Otto Jr. M.D. | | | | 22e ADDRESS 14 W. Coldspring Lane Baltimore, Maryland | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Jul 29 1986 | 23c NAME OF CEMETERY OR CREMATORY Roundhill Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Felton York Penna. |
| 24 FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a DATE REC'D. BY REGISTRAR 28 1986 | |
| | | | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3, it should be detached for use as the burial-transit permit. Then please remove carbon portions. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-14166

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner will be required to be called before burial.)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 2 4

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Nathan C. Viney | | MONTH DAY YEAR 7 29 86 | |
| 3. SEX MALE | | 4. RACE BLACK | |
| 5. DATE OF BIRTH MONTH DAY YEAR 9 13 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE Md. | | 13a. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT Marie Viney | | ADDRESS 422 Dennison St.-#21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>CARCINOMA - PROSTATE & METASTASIS</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10/85</u> , 19 <u>85</u> , to <u>7/2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Norman A. Keeman MD | | 22c. DATES SIGNED 7/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman B. Kleiman, M.D. | | 22e. ADDRESS 3803 Edmondson Avenue-#21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 08-04-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F.H. | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | |
| 25b. REGISTRAR'S SIGNATURE Norman A. Keeman | | | |

3311

CONFIDENTIAL

CONFIDENTIAL

00-13654

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 0 0 2 5
REG. NO.

| | | | | | |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Teresa M. Wade | | July 22, 1986 | | 9:45P ^M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | 11-18-1931 | 54 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Balto., MD. | U.S.A. | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore, Md. | 3403 E. Northern Pkwy. 21206 | | Book Keeper | | All State |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS / ZIP CODE | | |
| Md. COUNTY Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Boilers 3403 E. Northern Parkway-21206 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Benjamin W. Knach | | Cecilia Nelka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | 216-28-4892 | Cecilia A. Knack - 3403 E. Northern Pkwy. 21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>abdominal & polyc metastases</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ovarian cancer</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/22/86 to 7/23/86, that (I/we) last saw the deceased alive on 7/22/86, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| FAULKNER | | | | 7/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| FAULKNER | | 2300 Dulany Valley Rd Stella Mans Hospice 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7-26-86 | St. Stanislaus Cemetery | Balto., Md. | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| John C. Miller Inc-6415 Belair Rd.-21206 | | | JUL 25 1986 | | |



Pharmacia

obtaining - picture instructions

owning - covering

CO. Fairbairn

FAIRBANKS

7/22/82

2000 Duluth, Minnesota
Salem, Oregon 97057

00-13051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 20026 | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Wake Myrtle V.H. Wake | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 19 86 | | | 2b. HOUR 13.06 M | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 24 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1945 Edmondson Ave 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Holmes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie tabb | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | | | |
| 16b. SOCIAL SECURITY NO. 213-38-2007 | | 17. INFORMANT ADDRESS Esther Sterling | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular accidents, Hypertension, Previous MI | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 7.14.86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pressure Ulcers | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6.29.19.86 to 7.19.19.86, that (1) (we) lost saw the deceased alive on 7.17.19.86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 7.19.86 | |
| 22b. SIGNATURE Antoine G. Tohmen | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTOINE G TOHMEH | | 22e. ADDRESS Bon Secours Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westport, B.C. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Charles A. Rice FSPA 1300 Eutaw Pl, | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Ponder | | | | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other requirement, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 20027 REG. NO. | |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD WILLIAM WALKER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 2 86 | | | 2b. HOUR 1602 P.M. | | |
| 3. SEX M | | 4. RACE Col | | 5. DATE OF BIRTH MONTH DAY YEAR 5 14 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Auto. Repairs | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 900 Caton Ave 21229 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Tom Walker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erle Green | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 217-05-1788 | | 17. INFORMANT ADDRESS Mary F. Walker - 1810 Rayner Ave 21217 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) left cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/28 19 86 , to 7/2 19 86 , that (I) (we) last saw the deceased alive on 7/2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Moonhee Lee | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/2/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moonhee Lee | | | | 22e. ADDRESS 900 Caton Ave. Baltimore St. Agnes Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY Keeler Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Md. | | | |
| 24. FUNERAL DIRECTOR NAME Charles H. Powell | | | | ADDRESS 1206 W. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE W. J. Anderson | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH86 20028
REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-------------------------|--|---|--|--------------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| WILLIAM | | Richard | | WALLACE | | | | 7a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | | White | | 10 9 1958 | | 27 YRS. | | | | | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Missouri | | U.S.A. | | | | | | | | | | Baltimore City | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | Key Medical Center | | Groundsman - Baltimore County | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | Baltimore | | Edgemere | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2501 Lakeview Avenue | | | | | | | | | | 21219 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| James | | David | | Wallace | | Suzie | | | | | | | | | | | | Dambach | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 404-94-3097 | | Mary J. Wallace | | Same as 13e | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Stab wound of chest & abdomen and cuts of wrist and neck | | | | | | | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | 3:15 P.M. 7-14-1986 | | Self-inflicted. | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | home | | 2501 Lakeview Ave., Essex, Baltimore | | | | | | | | | | | | | | MD | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | M.D. Assistant | | 7-15-86 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD | | 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | |
| Cremation | | 7/18/1986 | | Westview | | Baltimore | | | | | | | | | | | | Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Duda-Ruck, Inc. | | JUL 18 1986 | | | | | | | | | | | | | | | | | |
| 7922 Wise Avenue | | Dundalk, Maryland | | 21222 | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 20029

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|--|--|---|--|---|--------|---|-------------------|-------------------------------|-----|------------------|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | JUSTINA E WALSH | | | | | 7/27/86 | | | | 3:45 A.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| F | | W | | 7/13/25 | | 60 | | MONTHS | | DAYS | |
| | | | | | | | | | | | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA | | Ba H | | | | Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | University of Maryland | | 20701 4453 | | GROCERY STORE | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, ZIP CODE | | | |
| An D | | Balt | | Balt | | YES | | 325 Carrollton 21223 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | |
| unk | | unk | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 207014453 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Large pleural effusions</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Breast Carcinoma</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>86</u> , to <u>7/27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| Sary C Papuchis | | MD | | 7/27/86 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| PAPUCHIS | | 22 S Green St Balto MD 21210 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Removal | | 1-30-86 | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | | | | | |
| Anatomy Board | | Balto., Md. | | AUG 5 1986 | | Julia Bender-Rudner | | | | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 6 2 0 0 3 0 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) STEPHEN Michael WALSH | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 22, 1986 | | 2b. HOUR 10:37 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 4, 1950 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 yrs. YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | 12b. KIND OF BUSINESS OR INDUSTRY Building | | | |
| 13a. STATE Md. | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 308 Bachmans' alley Road 21157 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stephen J. Walsh | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Matheson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1969-1972 | | 17. INFORMANT 308 Bachman Valley Rd. Stephen J. Walsh Westminster, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia, AIDS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mins 5 mins 5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 17</u> , 19 <u>86</u> , to <u>July 22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Serri Gantt</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Serri Gantt</u> | | | | 22e. ADDRESS 600 North Wolfe St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 25, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cem. Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR <u>H. E. Schmitt</u> | | | | 25a. DATE REC'D. BY REGISTRAR JUL 25 1986 | | 25b. REGISTRAR'S SIGNATURE <u>John T. Smith</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial or cremation.

88-14429

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|----------------------------------|--|--|--|--------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 86-20031 | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| LOUIS | | s | | tuart | | WALTERS | | JULY 25, 1986 | | 10:03 A | | | |
| 3. SEX | | Male | | 4. RACE | | White | | 5. DATE OF BIRTH DAY MONTH YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| | | | | | | | | June 23, 1923 | | 63 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S. | | | | BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR | |
| BALTIMORE | | JOHNS HOPKINS HOSPITAL | | | | | | | | Retired | | O. & P. Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS, ZIP CODE | | | | | | | | | |
| W. Va. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt. 2, Box 295 | | 99999 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| Roy E. Walters | | Irene Stuart | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | 578-26-7924 | | Eleanor L. Walters | | Rt. 2, Box 295 Harpers Ferry, W. Va. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT CAROTID BLOWOUT DUE TO, OR AS A CONSEQUENCE OF (b) RECURRENT LARYNGEAL CANCER DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINUTE ≈ 4 MONTHS | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 7/22/86 | | RIGHT CAROTID BLOWOUT | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/18, 1986, to 7/25, 1986, that (I) (we) lost saw the deceased alive on 7/25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| RAYMOND L. SCHATT, MD | | MD | | | | 7/25/86 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| RAYMOND L. SCHATT, MD | | JOHNS HOPKINS HOSPITAL, 601 N. BROADWAY, BALT. MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Cremation | | July 26, 86 | | Omps Crematory | | Winchester Fred. Va. | | | | | | | |
| 24. FUNERAL DIRECTOR | | P.O. Box 388 | | DATE RECEIVED BY REGISTRAR | | | | | | | | | |
| Douglas R. Snowden | | Charles Town, W. Va. | | JUL 31 1986 | | | | | | | | | |



RECEIVED
FEB 21 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

0-13582

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 9 6 | | 2 0 0 3 2 | |
|---|--|--|--|--|--|--|--|--|--|-------------------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ANNA | | | | CWARCZYNSKI | | 7 | | 24 | | 1986 | | 12:50 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | | WHITE | | 07 / 25 / 1894 | | 91 | | YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| POLAND | | U.S.A. | | | | BALTIMORE CITY, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BALTIMORE | | GOOD SAMARITAN HOSPITAL | | TAVERN OWNER | | TAVERN | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3316 BEVERLY Road #21214 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| MARCIN | | JOSEPHINE | | NO | | 212-05-5410 | | WANDA H. ANDRYSZAK | | 3316 BEVERLY Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/15/86 to 7/24/86 | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15/86 to 7/24/86, that (I) (we) last saw the deceased alive on 7/24/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Sireesh K. Tripuraneni | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/24/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| SIREESH K. TRIPURANE NI | | | | | | Good SAMARITAN HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| BURIAL | | 7/28/86 | | ST. STANISLAUS CEM. | | BALTIMORE | | | | | | Md. | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| GEORGE A. WEBER & SONS INC. - 705 S ANN ST. | | | | | | JUL 28 1986 | | Davidson-Hendall | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 0 0 3 3
REG. NO.

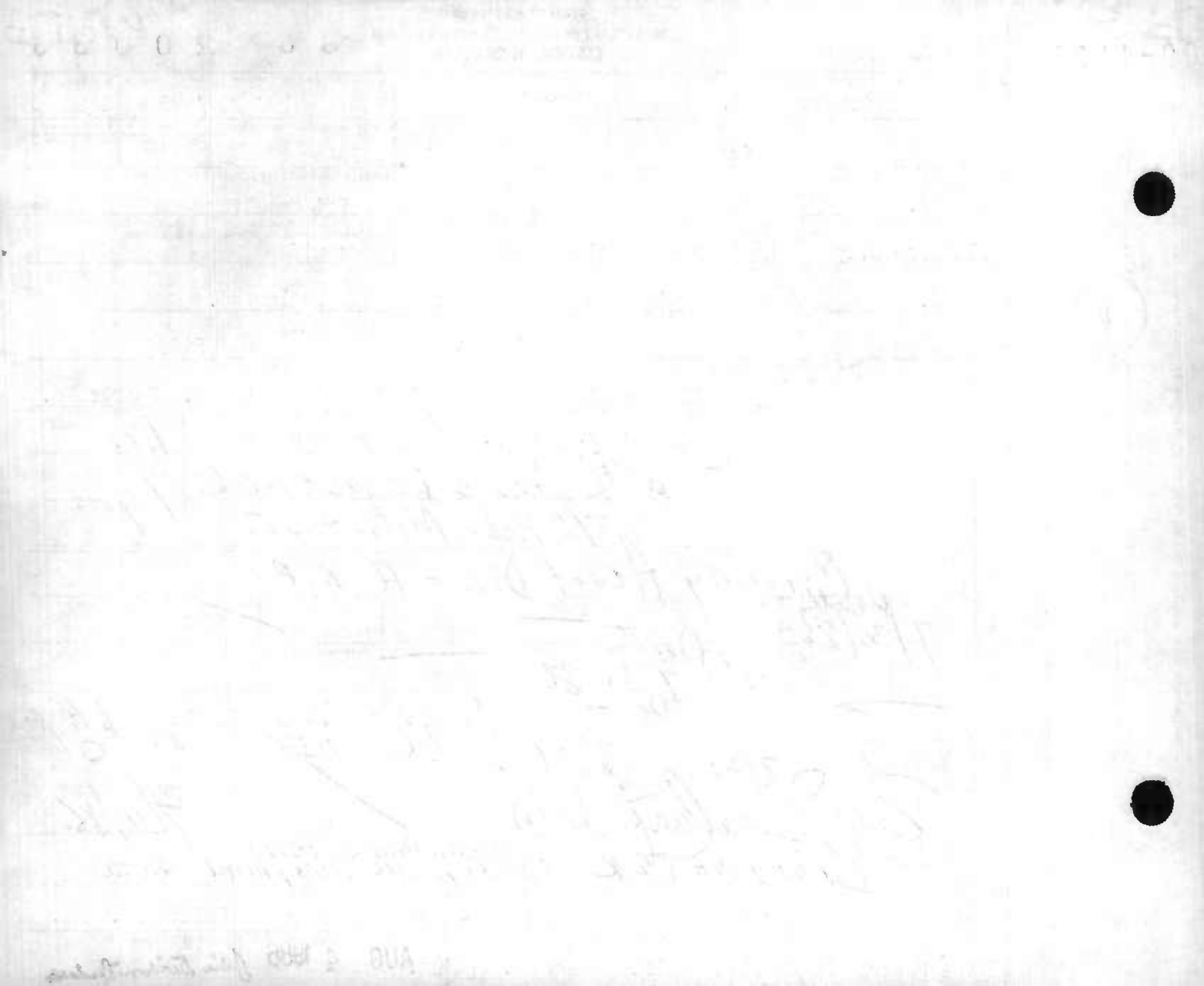
| | | | | | | | | | | |
|---|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth J. Warehime | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 / 30 / 86 | | | 2b. HOUR 2 am M | | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 7 23 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9. CITIZEN OF WHAT COUNTRY? usa | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore City | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 103 Butler Rd. 21133 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abarham Sutton | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Fife | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-32-0919 | | | 17. INFORMANT ADDRESS Elaine Cofiehl 16506 Dubbs Rd. Sparks Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b). DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Cardio-respiratory Failure with CANCER Tongue & Neck with Prob. Metastasis | | | | | | | | Drs. 1 yr. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | |
| Crownery Heart Dis. + H.B.P. | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/30/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Death | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 30 7 30 86 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PUBLIC PLACE) Death | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Longview N.E. Home Baltimore Md. | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 7/29 to 7/30, 1986, that (ii) (we) lost saw the deceased alive on 7/29, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J. Broadwater MD | | | 22c. DEGREE MD | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED 7/31/86 | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) J. Broadwater | | | 22g. ADDRESS 10 WARDEN ROAD SUITE 110 COCKEYSVILLE, MARYLAND 21030 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY Black Rock Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Butler Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home | | | ADDRESS 11824 Reisterstown Rd. Reisterstown | | | 25a. DATE REC'D. BY REGISTRAR AUG 4 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0-13455

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Grace Virginia Warfield | | 2a. DATE OF DEATH MONTH DAY YEAR 7 22 86 | | 2b. HOUR 10 20 P.M. | | | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 10 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN Linthicum | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George E. Main | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lare | | 13d. STREET ADDRESS / ZIP CODE 111 Charles Road 21090 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-7308 | | 17. INFORMANT ADDRESS 21090 Louise Dascomb 503 Oak Grove Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Dehydration, Urinary tract infection, Pneumonia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from July 15, 19 86, to July 22, 19 86, that (1) (we) lost the deceased alive on July 22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) see the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Barbara Socha, M.D. | | | | 22c. DATE SIGNED 7/22/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Socha | | | | 22e. ADDRESS St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 07/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cem. | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Monrovia, Frederick, MD | | 24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home, Catonsville, MD | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 25 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Hodges | | | | | | | |

000-13892

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 0 0 3 5

REG. NO.

1. FOR
STATE
REGISTRAR

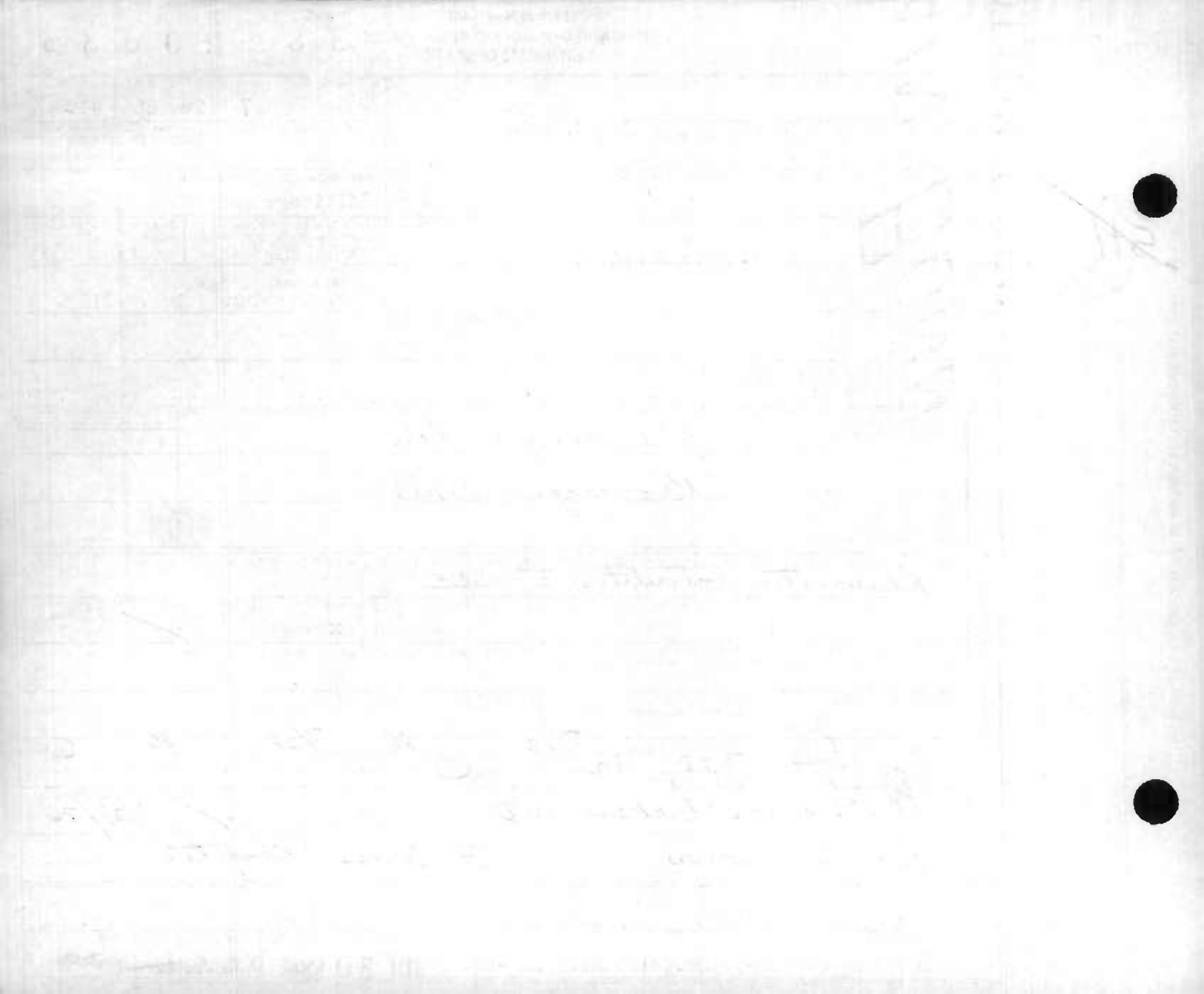
| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR C. WARREN | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 86 | | 2b. HOUR 4:29 P ^M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 5 8 1918 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician | 12b. KIND OF BUSINESS OR INDUSTRY Westinghouse | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Emmett Warren | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Lee | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WW II 218-07-8975 | 17. INFORMANT ADDRESS Stella A. Warren 3509 Mac Tavish Ave. 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brondopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Rheumatic valvulitis c SBE</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>7/13</u> 19 <u>86</u> , to <u>7/28</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>7/28</u> 19 <u>86</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <u>William J. Hicken MD</u> | | DEGREE MD | | 22c. DATE SIGNED <u>7/29/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W.M. J. HICKEN</u> | | 22e. ADDRESS <u>St Agnes Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/1/86 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | 24b. ADDRESS 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1986 | |
| 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-12830

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BEATRICE P. WASHINGTON | | | | | 2a. DATE OF DEATH - MONTH DAY YEAR 7-17-1986 | | 2b. HOUR 12²³ A.M. | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3-12-1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3224 PRESSTMAN ST. / 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIE GRIFFIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSANNA UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 212-09-9276 | | 17. INFORMANT HERBERT WASHINGTON BALTIMORE, MD. 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST DUE TO DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE VASCULAR DISEASE, CABHD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7-7 19 86 , to 12:23 AM, 7-17 19 86 , that (1) we last saw the deceased alive on 7-17 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE VORPER MD | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-17-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VORPER | | | | 22e. ADDRESS 8. H. B. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY MD. NATIONAL MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS NUMER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 1-8 1986 | | 25b. REGISTRAR'S SIGNATURE Jana K. Gordon | | | |

BEATRICE D. WHITTINGTON

7-17-1938

BALTIMORE CITY

ROBINSON

111 E. EIGHTH ST. / BALTIMORE

UNKNOWN

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1938 FEBRUARY 27

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00-11363

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC'D NO.

20037

| | | | | | | |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daniel Washington | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 7 2 86 12:25 AM | | | |
| 3. SEX male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 02 23 14 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH BAIT. CITY MD | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD | | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE CITY | | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Austin Washington | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Walls | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 717-07-6501 | | 17. INFORMANT ADDRESS EMMA Johnson 4009 Barrington Rd | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) METASTATIC squamous cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <input type="checkbox"/> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/11, 19 86, to 7/2, 19 86, that (I) (we) lost saw the deceased alive on 7/1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Barry Wertheimer | | DEGREE MD 7008 | | 22c. DATE SIGNED 7/2/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 5847 B Western Run Dr. BAIT. MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | |
| 23d. LOCATION CITY OR TOWN Randallstown | | COUNTY Md | | STATE | | |
| 24. FUNERAL DIRECTOR BAME March Funeral Home West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR JUL 3 1986 | | 25b. REGISTRAR'S SIGNATURE J. E. ... | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-13945

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 3 8

REG. NO.

| | | | | | | | | |
|--|---|---|-------------|--|-------------------------------------|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Earnest | MIDDLE - | LAST Washington, II WASHINGTON | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR P | |
| | | | | JULY 21, 1986 | | 3:31 M | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Male | Black | 7/20/1986 | | YRS 1 | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | USA | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | NONE | | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Aberdeen | | 13c. STREET ADDRESS / ZIP CODE 409 Dawn Court/21001 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Earnest - Washington, Sr. | | Dianne Davis | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | |
| NO | | N/A | | Earnest Washington, Sr., 409 Dawn Ct., Aberdeen, MD, 21001 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Persistent Fetal Circulation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>24 hrs</u> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Congenital Hydrocephalus, multiple Congenital Anomalies</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> 19 <u>86</u> to <u>7/21</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>7/21</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Harry C. Dietz MD</u> | | DEGREE MD | | 22c. DATE SIGNED 7/21/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harry Dietz MD</u> | | 22e. ADDRESS THE JOHNS HOPKINS HOSPITAL Doctors Lounge JHH | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace, Harford, MD | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 | | ADDRESS | | 25. DATE RECEIVED BY REGISTRAR JUL 28 1986 | | 26. REGISTRAR'S SIGNATURE <u>Julia Jackson-Rodgers</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked either "I" shows any injury, or other traumatic event, item 21b should be completed.

BP

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10-11587

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 0 0 3 9
REG. NO.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| GERALDINE WASHINGTON | | | JULY 2, 1986 | | | 09:15pm | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | | IF UNDER 1 YEAR | | |
| F | B | MONTH DAY YEAR 5 25 30 | 56 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | U.s.a. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | Housewife | | | Domestic | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| Maryland | | | | Baltimore | 13e. STREET ADDRESS 949 North Wolfe Street 21205 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| George T. Smith | | | Annie | | | Stringfield | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| No | | | 219286606 | | | Annie Smith 949 North Wolfe Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | 30 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive hemoptysis/hematemesis</u> | | | | | | | | 10-15 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>esophageal carcinoma</u> | | | | | | | | 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| None | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> , 19 <u>86</u> , to <u>July 2</u> , 19 <u>86</u> , that (II) (we) last saw the deceased alive on <u>July 2</u> , 19 <u>86</u> , and that in (III) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death) | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | |
| <u>Donald R. Chabot, MD</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| <u>Donald R. Chabot MD</u> | | | <u>Johns Hopkins Hosp. 600 N. Wolfe St., Baltimore, MD 21205</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | 7/7/86 | | Arbutus MEmorial Pk. Arbutus, | | Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| March Funeral Homes 1101 East North Avenue | | | | | JUL 7 1986 | | <u>John Davidson-Randall</u> | |

RELEASED NON-MEDICAL DR. KAUFFMAN PER MR. HENRY
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be signed by the attending physician within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WASHINGTON, D.C. 20540
JUL 87
JUL 87

5

00-14282

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20040

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|---------|-------------------|--|--|------------------------|--|--|----------------|------------------|--|---|--|---------|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b HOUR | | | |
| William W. Washington | | | | | | 7/ 31/19 86 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| M | | B | | 2 6 56 | | 30 YRS. | | | | | | 7/ 31/19 86 | | A M | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.s.a. | | | | | | | | Baltimore City, MD | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | St. Agnes Hospital | | | | Wells Fargo | | | | Security | | | |
| 13a STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| John | | | | Cordelia | | | | no | | | | 219623117 | | | |
| 17 INFORMANT | | | | 17 ADDRESS | | | | 17c STREET ADDRESS | | | | 17d. CITY OR TOWN | | | |
| Teresa Washington | | | | 405 Beechfield Ave. | | | | 21221 | | | | Apt.F | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Embolus | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | M.D. Assistant | | | | MEDICAL EXAMINER | | | | 7/31/86 | | | |
| Gregory R. Kauffman, M.D. | | | | ADDRESS | | | | 111 Penn St. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION | | | |
| Burial | | | | 8/5/86 | | | | Arbutus | | | | Arbutus | | | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D. BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| WM.C.MARCH F/H Inc. 1101 East North Avenue | | | | AUG 4 1986 | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

CHURCHMAN BOND



00-125291-

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

20041

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERNEST Eugene WATERS | | | 2a. DATE OF DEATH MONTH DAY YEAR July 13 86 | | | 2b. HOUR 3:15 P.M. | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 30 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 52 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland? | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY ? | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY BALT | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2705 Elliott Dr. Balt. 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST - - - | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Robinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO? | | | 16b. SOCIAL SECURITY NO. 221-30-0268 | | 17. INFORMANT ADDRESS char + Marion Cook 2705 Elliott Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 86 , to 7/13 , 19 86 , that (I) (we) lost saw the deceased alive on 7/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Andrew Weinstein, MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/13/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Weinstein, MD | | | | | 22e. ADDRESS 6605 Copper Ridge Dr Balt, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

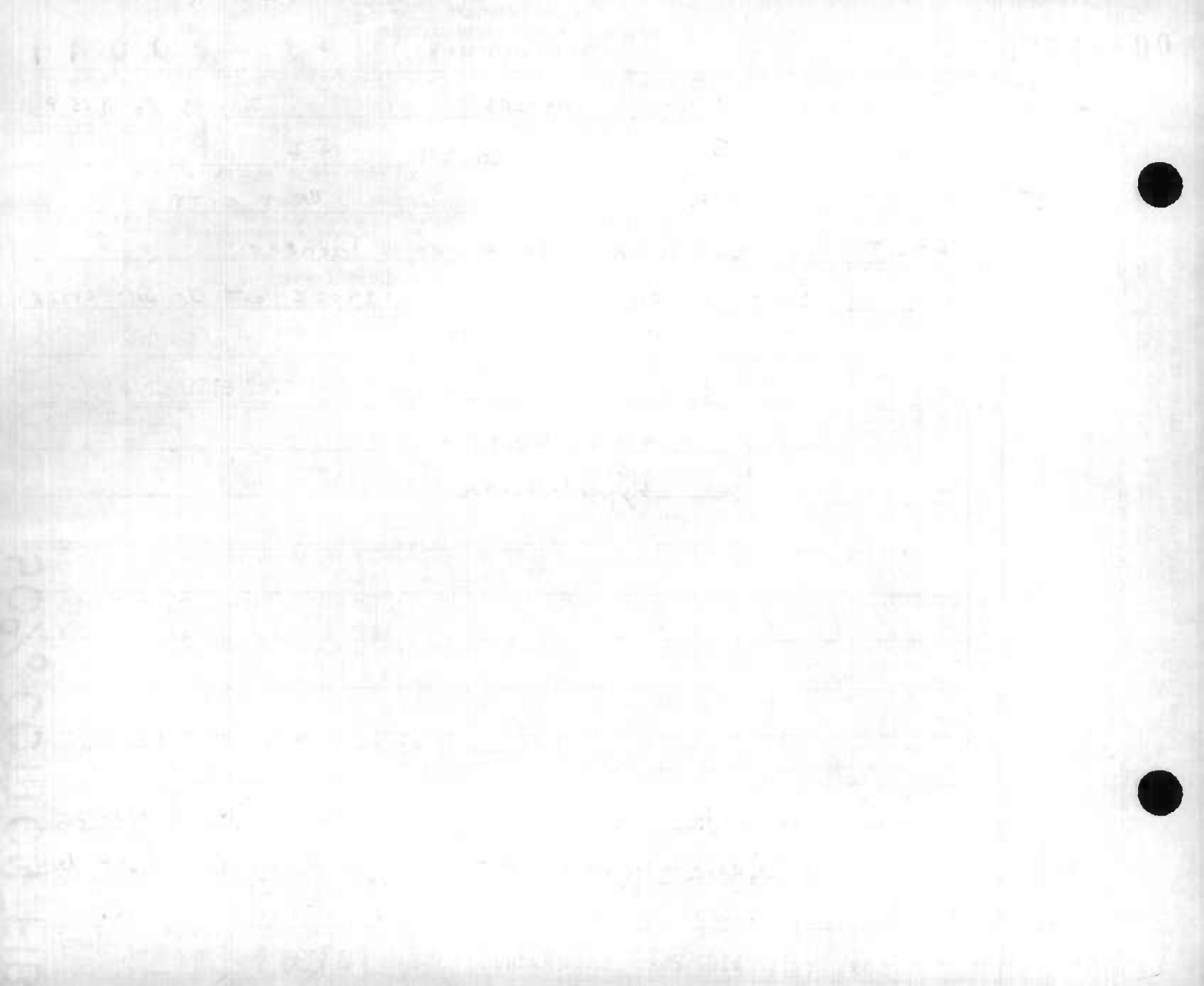
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP



0-12235

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20042
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) John William Waters | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 07 86 | | 2b. HOUR 11:21 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10 21 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Vernon Care Ctr. 808 St. Paul St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Operator | 12b. KIND OF BUSINESS OR INDUSTRY Grocery | |
| 13a. STATE Md. | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henderson Waters | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Virginia Bagent | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO 327-26-8856 | | 17. INFORMANT ADDRESS 827 Arneliffe Road | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Ascend**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Cancer with metastasis**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-10-85 to 6-10-85 , that (I) (we) lost saw the deceased alive on 6-10-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | |
| 22b. SIGNATURE Ashok K Chatterjee | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 7/8/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASHOK K CHATTERJEE | | 22e. ADDRESS 3927 ANNAPOLIS ROAD 21207 | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/12/86 | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Loudoun Heights, Virginia |
| 24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, WV 25425 | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Gladys Beck Watson | | | 2a. DATE OF DEATH MONTH 7 DAY 23 YEAR 86 | | 2b. HOUR 2:57 A.M. |
| 3. SEX F | 4. RACE White | 5. DATE OF BIRTH MON 6-9-1915 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4509 Clareway 21213 |
| 14. FATHER'S NAME FIRST Ernest MIDDLE Beck LAST Beck | | 15. MOTHER'S MAIDEN NAME FIRST Maude MIDDLE H. LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-12-4614 | | 17. INFORMANT North White Marsh, Md. Ernest J. Watson, 11205 Loreley Beach Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) inferior myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH N |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/22 , 19 86 , to 7/23 , 19 86 that (I) (we) last saw the deceased alive on 7/23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Peter White, Jr. MD | | DEGREE | | 22c. DATE SIGNED 7/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER WHITE, JR MD | | 22e. ADDRESS Francis Scott Key | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 23d. LOCATION CITY OR TOWN Balto., Md. | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR FNAME Leonard J. Ruck, Inc., 5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR JUL 24 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

BP

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• 2850000 2100-51-55

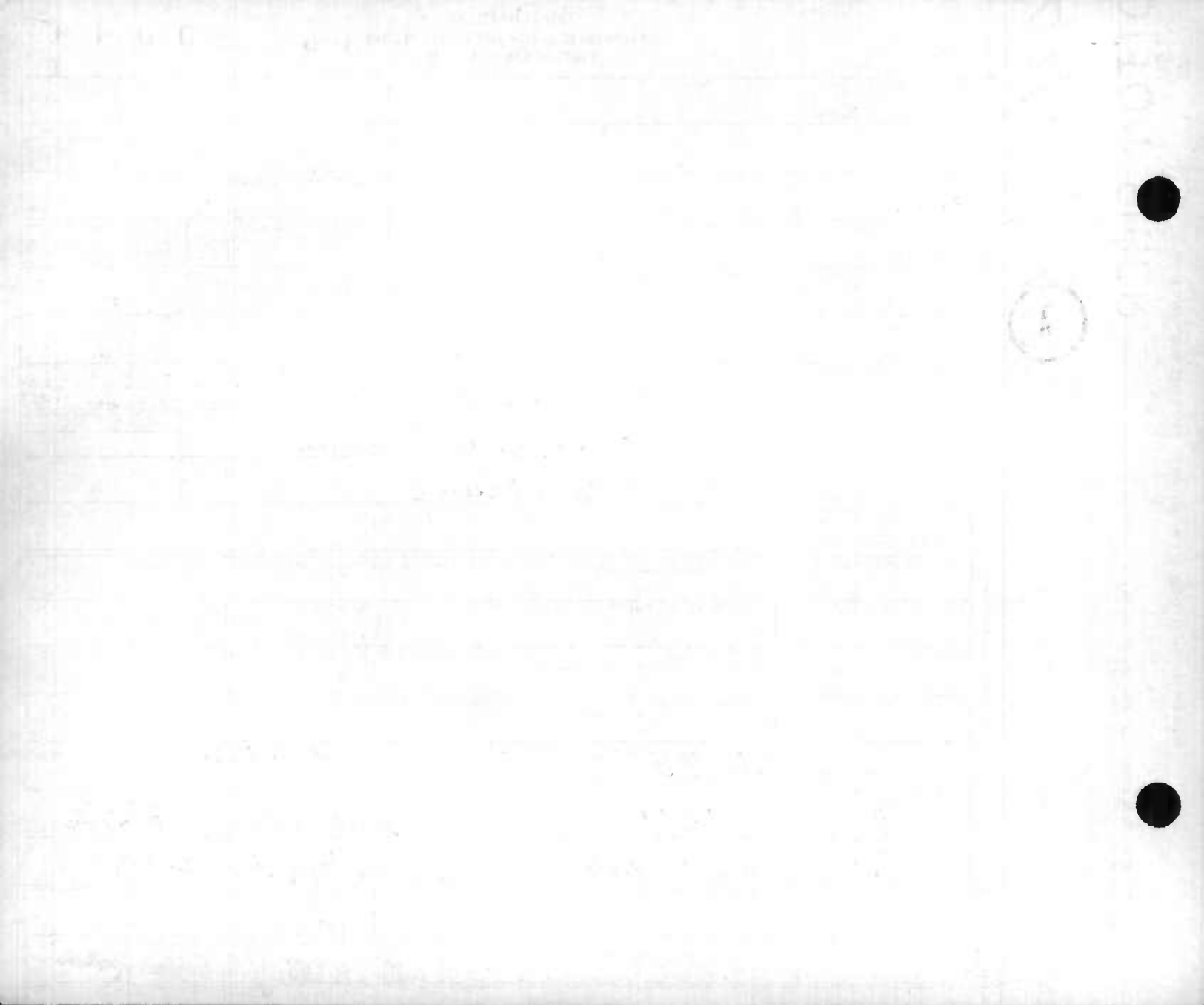
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19-36-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|--|--|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) HERMAN WATTS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 31 1986 | | | 2b. HOUR M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5 15 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH MARYLAND | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3013 GWYNNS FALLS PARKWAY | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIPPING CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY FORT MEADE | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3013 Gwynns Falls Baltimore, Maryland 21216 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James R. Watts | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Pitts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 11 | | 17. INFORMANT Gertrude W. Watts | | ADDRESS 3013 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19____, to <u>7/31/86</u> , 19____, that (I) (we) lost saw the deceased alive on <u>7/26/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>J. Schorofsky, MD.</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 8/5/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. SCHOROFSKY MD | | | 22e. ADDRESS 4734 Park Heights Ave 21215 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/5/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 8 1986 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | |



0-13564

Cert. amended by M.E. 9/3/86 dad
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

86 20045

REG. NO.

| | | | | | |
|---|---------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Weatherly | | 2a. DATE OF DEATH MONTH DAY YEAR 7/22/86 | | 2b. HOUR 1220 AM | |
| 3. SEX ♂ | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 1 13 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Balt City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Md Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13a. STATE MD | | 12b. KIND OF BUSINESS OR INDUSTRY RESTAURTOR | | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARVEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE | | 13b. STREET ADDRESS / ZIP CODE 405 Somerset St 21853 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 193 18 4381 | | 17. INFORMANT ADDRESS LENA LEE WEATHERLY SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 9289 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic and Acute Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a Renal failure, Diabetes, Aspiration Pneumonia, HCVD | | | | | |
| 19a. DATE OF OPERATION 7/2/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. ? 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) apparently fell and struck head | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 405 Somerset St., Princess Anne, Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/2/86 to 7/22/86 , that (I) (we) last saw the deceased alive on 7/22/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John Joseph Ragheb | | 22c. DATE SIGNED 7/22/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ragheb | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-25-86 | | 23c. NAME OF CEMETERY OR CREMATORY MT. HOPE A.M.E. ZION | |
| 24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell | |
| 26. ADDRESS RT. # 2, BOX 920 SALISBURY, MD | | 27. LOCATION CITY OR TOWN COUNTY STATE PRINCESS ANNE SOMERSET MD | | 28. ADDRESS 22 S. Green St | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: When 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.


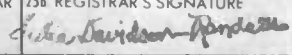
BP

BOX-COTTON FIREB



00-11559

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Enma G. Webb | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7/ 5/ 19 86 | | 2b. HOUR 4:30 P | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 13 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 5/ 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2017 Winford Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse R N | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2017 Winford Road 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter Deveau | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Saulnier | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 216-24-9898 | | | | 17. INFORMANT ADDRESS 21204 Frances A. Deveau 8140 Loch Raven Blvd. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Drug Overdose DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/ 5/ 19 86 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject ingested drugs | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2017 Winford Rd., Balto. City, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7/6/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE July 9 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | |

07/B4

25M

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 DHMH - 17
(VR A15 ME (5))

0-11258

00-14067

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES M WEILER | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 27 86 | | 2b. HOUR 5:08A | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 25 07 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP. | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD | | 15b. COUNTY ANN ARUNDEL ANNAPOLIS | | 15c. CITY OR TOWN ANNAPOLIS | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST George Henry Hinkins | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Susan Mowery | | 18. STREET ADDRESS / ZIP CODE 115 RIVERVIEW AVE 21401 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 20. SOCIAL SECURITY NO. 214-720542 | | 21. INFORMANT HOSPITAL RECORDS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25' | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 JULY 1986 to 27 JULY 1986 , that (I) (we) lost saw the deceased alive on 24 JULY 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) see the body after death. | | | | | | |
| 22b. SIGNATURE  A.H. KLEIN | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/27/86 | | |
| 22d. PHYSICIAN'S ADDRESS 3001 S. HANOVER ST. BALTIMORE | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE SUMMIT P.G. MD. | | 23e. DATE REC'D. BY REGISTRAR JUL 30 1986 | | | | |
| 23f. REGISTRAR'S SIGNATURE  | | 23g. REGISTRAR'S SIGNATURE | | | | |

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

DATE: [illegible]
BY: [illegible]

RE: [illegible]

00-12962

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20048

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|---------|---|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| OSCAR ZELIG WEINTRAUB | | | | 7/14/86 | | | | 6.05 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE | | 7. YEARS (LAST BIRTHDAY) | | 8. IF UNDER 1 YEAR | |
| MALE | White | MONTH DAY YEAR | | 77 | | YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| RUSSIA | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | SINAI - HOSPITAL | | BUTCHER | | MEATS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3401 PINKNEY RD. #21215 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | NO (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 218-32-1982 | | MRS. GUSSIE WEINTRAUB | |
| DAVID | | WEINTRAUB | | | | | | 3401 PINKNEY RD. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH | | 19. SOCIAL SECURITY NO. | | 20. INFORMANT | | 21. STREET ADDRESS / ZIP CODE | | 22. KIND OF BUSINESS OR INDUSTRY | |
| PART I. DEATH WAS CAUSED BY: | | 218-32-1982 | | MRS. GUSSIE WEINTRAUB | | 3401 PINKNEY RD. BALTO., MD 21215 | | MEATS | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | CITY OR TOWN COUNTY STATE | |
| | | P.M. 19 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| 6/12/86 to 7/14/86, that (I) (we) last saw the deceased alive on 7/14/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | T. Redup | | 7/14/86 | | T. Redup | | SINAI HOSPITAL | |
| | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| | | M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| BURIAL | | 7/15/86 | | BETH JACOB | | CITY OR TOWN COUNTY STATE | | JUL 21 1986 | |
| | | | | | | FINKSBURG CARROLL MARYLAND | | JUL 21 1986 | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | JUL 21 1986 | | Julia Davidson-Rodriguez | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is only injury, or other traumatic event, the medical examiner must file a report of death.

2000 NOTION HBB

MINIATURE

END



0-12333

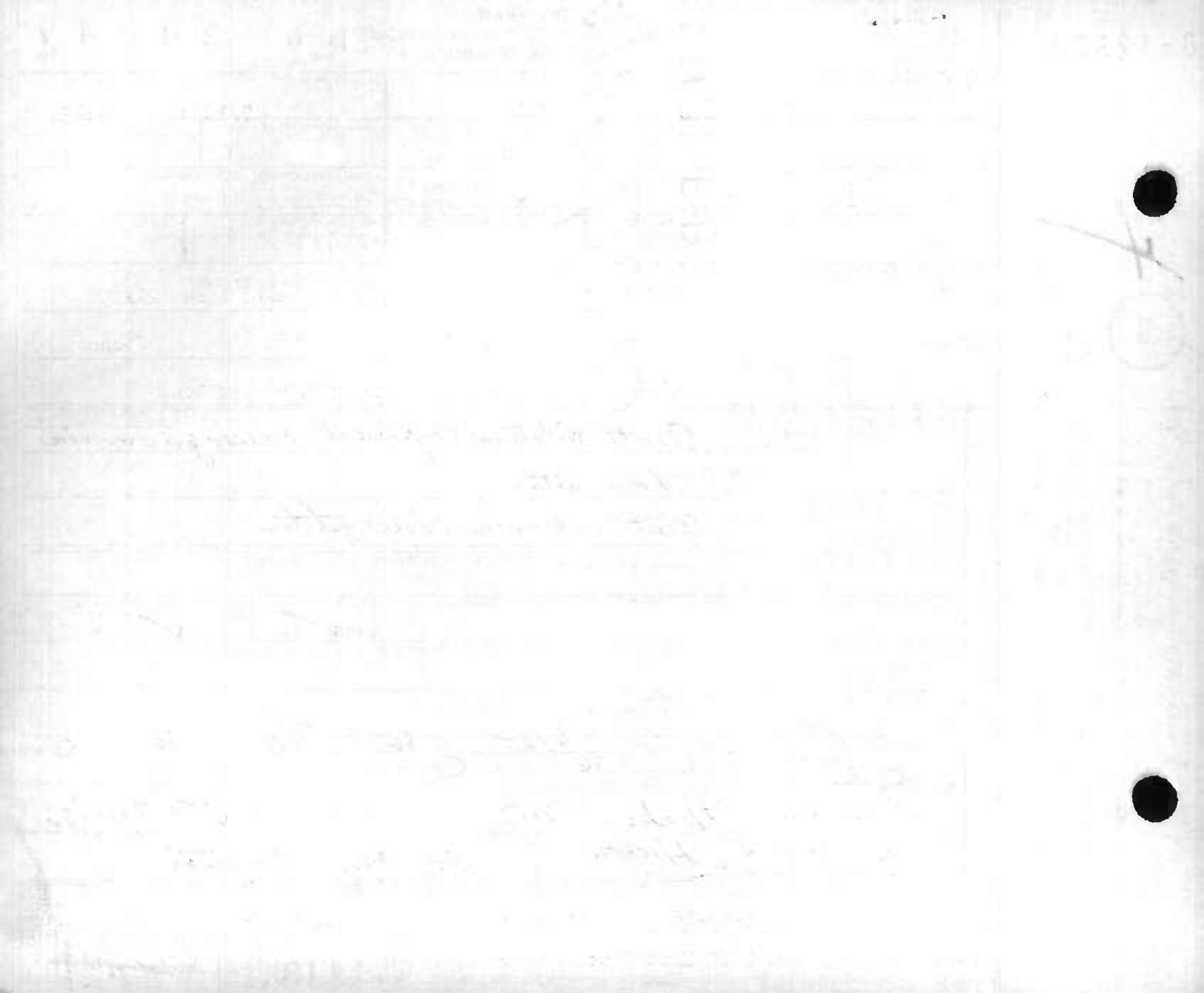
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| Film #618 Item 14 8/19/86 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 86 20049 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARA C WELLS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/10/86 | | | 2b. HOUR 7:15 P M | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 6 25 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.s.a. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City' MD. | | | | |
| 10. CITY OR TOWN OF DEATH altimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Eliza Elijah Johnson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Mae Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 224443811 | | 17. INFORMANT ADDRESS Louise Sowell 3233 Phelps Lane | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bilateral confluent bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cholangitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute & chronic cholecystitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/25 19 86 to 7/10 19 86, that (I) (we) lost saw the deceased alive on 7/10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE William J Hicken MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/11/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. VINNY SUTYA MD | | | | 22e. ADDRESS St Agnes Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR Wm. C. March F/H Inc. 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | |



00-12657

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 5 0

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dolores E. Wesley | | 2a. DATE OF DEATH MONTH DAY YEAR 7 13 86 | | 2b. HOUR 1147 ^P | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 1 30 28 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7a. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 11. KIND OF BUSINESS OR INDUSTRY | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALT. | |
| 15. FATHER'S NAME FIRST MIDDLE LAST Charles Johnson | | 16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Han | | 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 18. SOCIAL SECURITY NO. 216-22-3917 | | 19. INFORMANT Paul H. Wesley | | 20. ADDRESS 828 Lyndhurst Street | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension and Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Crispitations. | | | | | |
| 22a. DATE OF OPERATION | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 25. I certify that (I) (this hospital) attended the deceased from 6:25, 1986, to 7:13, 1986, that (I) (we) lost saw the deceased alive on 7/13/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 26. SIGNATURE Michael E. Collier, MD | | 26b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 26c. DATE SIGNED 7/13/86 | |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER, MD | | 27b. ADDRESS 3001 S. HANOVER ST. | | | |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 28b. DATE 7/17/86 | | 28c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | |
| 28d. LOCATION CITY OR TOWN Arbutus | | 28e. COUNTY MD | | 28f. STATE | |
| 29. FUNERAL DIRECTOR NAME March Funeral Home West 4300 | | 29b. ADDRESS Wabash Avenue | | 29c. DATE REC'D. BY REGISTRAR JUL 16 1986 | |
| 29d. REGISTRAR'S SIGNATURE | | 29e. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

COLORED PAPER

WAVE NEW YORK

100-100

00-11498

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20051

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) William Harman Wesselman | | | 2a DATE OF DEATH MONTH DAY YEAR 07-01-86 | | | 2b HOUR 12:00 PM | | | |
| 3 SEX Male | | 4 RACE Caucasion | | 5 DATE OF BIRTH MONTH DAY YEAR 06-21-06 | | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 00 00 00 00 | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 8b CITIZEN OF WHAT COUNTRY? United States | | 9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired- Genl | | 12b KIND OF BUSINESS OR INDUSTRY Supply Equip | |
| 13a STATE Baltimore | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore Maryland | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 139 Newburg Ave. 21228 | |
| 14a FATHER'S NAME FIRST MIDDLE LAST Henry Wesselman | | 14b MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Wheeler | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | |
| 16b SOCIAL SECURITY NO. 212-09-4192 | | 17. INFORMANT ADDRESS Donald Wesselman 67 Hiltop Road Ellicott City 21043 | | | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiogenic shock**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary artery disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/04/1986 , to 7/04/1986 , that (I) (we) lost saw the deceased alive on 1886 7/04 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE M. Nasir | | | | DEGREE | | 22c DATE SIGNED 7/04/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) NOUKHTAR NASIR | | | | 22e ADDRESS ST AGNES HOSP 900 CATON AVE. BALTO MD 21229 | | | |

| | | | | | | | |
|---|--|---------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 7-7-86 | | 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD | |
| 24 FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home, Catonsville, MD | | | | 25a DATE REC'D BY REGISTRAR JUL 7 - 1986 | | | |
| | | | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MADE IN U.S.A.



00-11941

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 5 2

REG. NO.

| | | | | | | | |
|---|--|--|---|---|------------------------|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ETHEL LAST WETZELBERGER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 - 7 - 86 | | 2b. HOUR 10:05 A.M. | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 27 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Md. | | 13b. CITY OR TOWN City | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 4234 Falls Rd 21211 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-01-1070D | | 17. INFORMANT ADDRESS Charles Wetzelberger Jr. 8321 Analee Ave 21237 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration → Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Aspiration following vomiting episode</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>History of Coronary Artery Disease</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION 6-10-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected total hip arthroplasty | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/29/86</u> , 19 <u>86</u> , to <u>7/7</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE <u>Robert L. Murrah Jr.</u> | | 22b. ADDRESS 201 E. UNIVERSITY PARKWAY | | 22c. DATE SIGNED 7/7/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. MURRAH JR. M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION Baltimore Md. STATE | |
| 24. FUNERAL DIRECTOR Burgee-Henss 3631 Falls Rd 21211 | | | | 25. DATE RECEIVED BY REGISTRAR JUL 10 1986 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

NEW YORK OFFICE

NEW YORK CITY

RECEIVED



1931 OCT 10 11 00 AM

RECEIVED

RECEIVED

00-13735

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20053

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lawrence F. Whalen</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>July 25 1986</u> | | 2b. HOUR <u>4⁰⁰ AM</u> |
| 3. SEX <u>male</u> | 4. RACE <u>White</u> | 5. DATE OF BIRTH MONTH DAY YEAR <u>June 7, 1912</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital, Balto. Md.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Boiler Maker</u> | 12b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> | | | 13b. COUNTY <u>-----</u> | 13c. CITY OR TOWN <u>Baltimore</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>James Joseph Whalen</u> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Catherine ----- Murphy</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>216-03-8702</u> | | 17. INFORMANT ADDRESS <u>Lillian Whalen, 1351 Jackson St. Balto. Md. 21230</u> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) severe COPD

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHhoursyears

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>86</u> , to <u>July 25</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>July 25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Helen Walker, MD</u> | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>July 25, 1986</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Helen Walker, MD</u> | | 22e. ADDRESS <u>Mercy Hospital Balto Md. 501 St Paul Pl.</u> | |

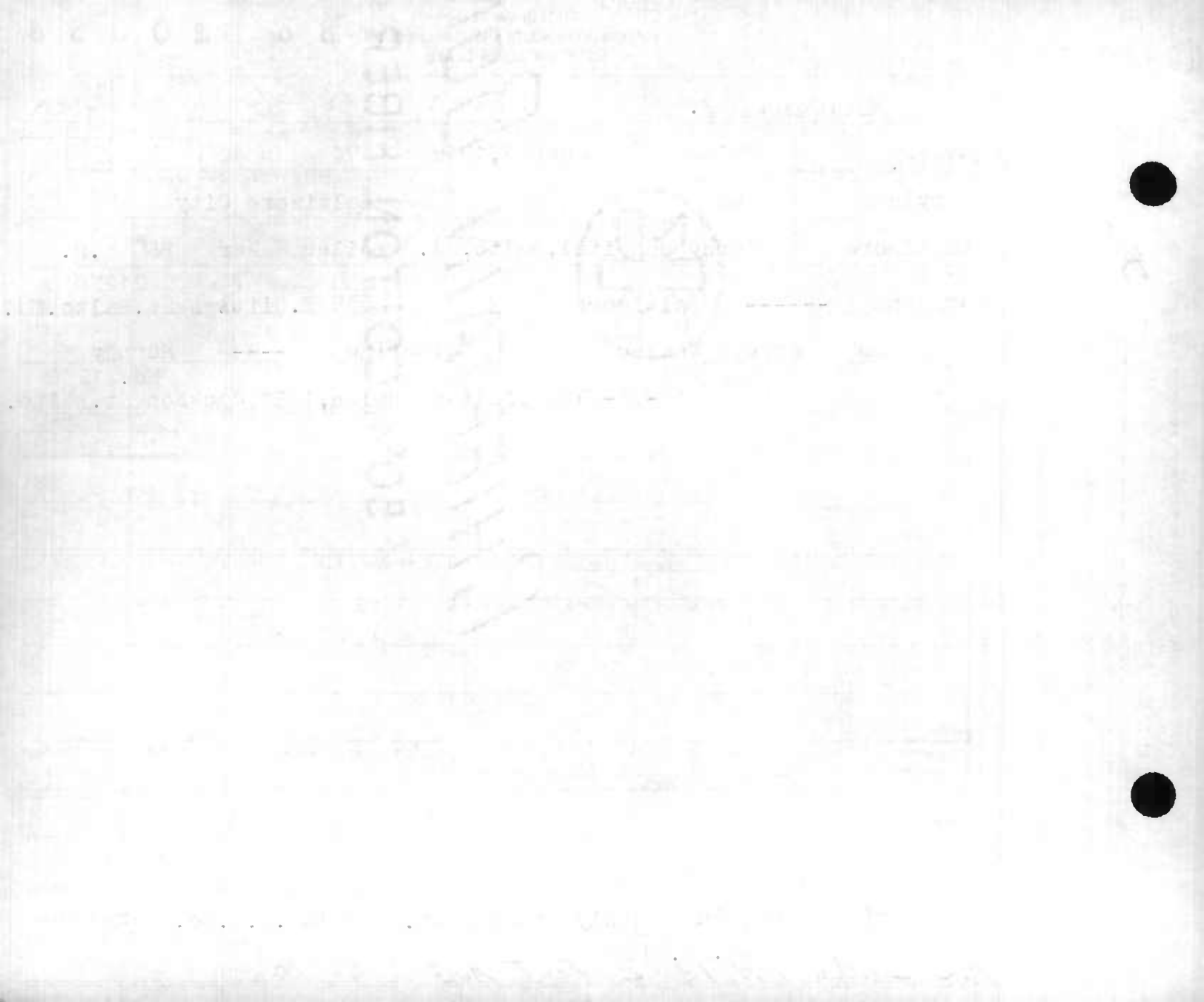
| | | | |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | 23b. DATE <u>7/28/86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemt.</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. A.A. Co. Maryland</u> |
| 24. FUNERAL DIRECTOR NAME <u>Mc Gully FH 130 E. Fort Ave</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 29 1986</u> | 25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Henderson</u> |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one.



00-13599

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECILIA MARY WHEELER | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1986 | |
| 3. SEX Female | | 2b. HOUR 1:47P M | |
| 4. RACE White | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS. | |
| 5. DATE OF BIRTH MONTH DAY YEAR March 14, 1914 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 309 Overlook Dr. 21093 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Hamilton Edmiston | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Mae O'Flynn | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-14-4096 | |
| 17. INFORMANT ADDRESS Albert W. Wheeler - same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Coronary Artery Disease; Renal Failure</u> | | | |
| 19a. DATE OF OPERATION <u>7/23/86</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured Aneurysm</u> | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) — | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> , 19 <u>86</u> , to <u>July 23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>G.M. Williams</u> | | 22c. DATE SIGNED <u>M.D.</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G.M. Williams</u> | | 22e. ADDRESS <u>606 Block, Johns Hopkins Hosp.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-28-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D BY REGISTRAR JUL 28 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician, it must be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18, show any injury or other traumatic event, if applicable, in item 18.



0-14123

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8620055

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ABRAHAM WHITE | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 30 86 | | | 2b. HOUR 10⁵⁵ AM | | | |
| 3 SEX M | | 4 RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 04 18 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH COUNTY BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LANICAN | | 12b. KIND OF BUSINESS OR INDUSTRY OFF Bldg | |
| 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H White | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Given | | | 13e. STREET ADDRESS / ZIP CODE 700 RAYMOND AVE 21201 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 217-05-7859 | | 17. INFORMANT ADDRESS David White 1711 McLean Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA / SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PROSTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 Year | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a CONGESTIVE HEART FAILURE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 07/27 , 19 86 , to 07/30 , 19 86 , that (I) (we) last saw the deceased alive on 07/30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Karl Salmen | | | | | | DEGREE MD | | 22c. DATE SIGNED 07/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR CEBSON | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY BAWKS CHURCH | | 23d. LOCATION CITY OR TOWN COUNTY STATE COLLETT IN MD | | |
| 24. FUNERAL DIRECTOR NAME Thom & son 638 N Gilman St | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove pages 1, 2, and 3, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, 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and 789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.

BP

00-11591

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 20056

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN WHITE | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1986 | | | 2b. HOUR 3:25A _M | | | |
| 3. SEX M. | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YRS. 9 4 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Box Co. | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS / ZIP CODE 918 Streeper ST 21295 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD WHITE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS Grace Oliver 918 Streeper St | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) PULMONARY CONGESTION

DUE TO, OR AS A CONSEQUENCE OF

(c) PROGRESSIVE END STAGE ALZHEIMERSAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 DAY

2+ YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

NONE

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>86</u> , to <u>7/7</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael R. Grunnett | | | | DEGREE MD | | 22c. DATE SIGNED 7/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRIMMETT, MICHAEL R | | | | 22e. ADDRESS 600 N. WOLFE ST BALTIMORE, MD | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Peanut Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City County MD | |
| 24. FUNERAL DIRECTOR NAME Locke Funeral Home 1304 N. Central Ave | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1986 | | 25b. REGISTRAR'S SIGNATURE John Anderson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to Bureau of Health and Mental Hygiene, Department of Health and Mental Hygiene, State Dept. of Health and Mental Hygiene prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



00-12696

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20057

1 - FOR
STATE
REGISTRAR

REG. NO.

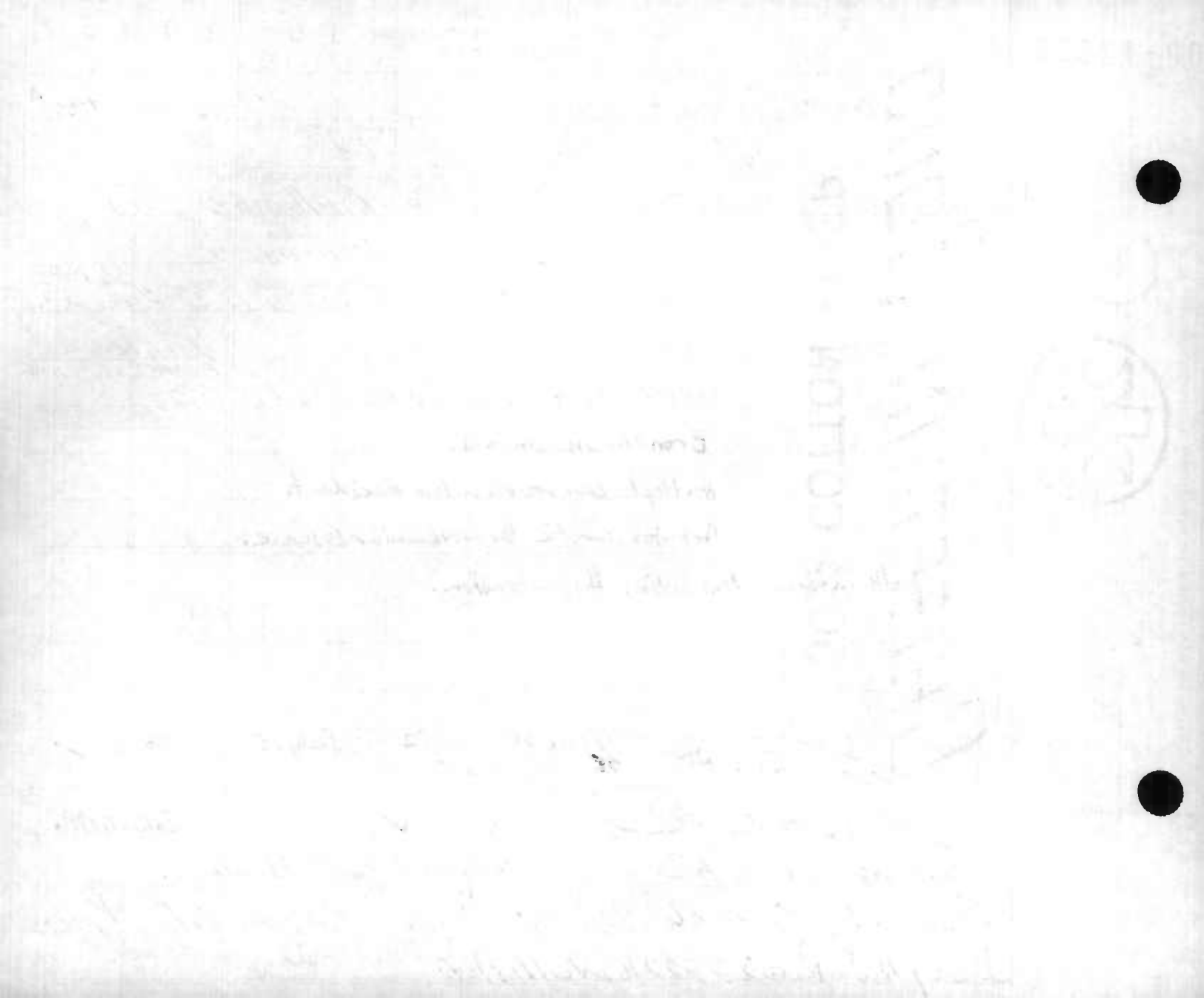
| | | | | | | | | | |
|--|--|---|---|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Naomi Bessie White</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7-15-86</i> | | | 2b. HOUR <i>7:30 A</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>col</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12-3-1917</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balt. Md.</i> | | 9. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 12. CITY OR TOWN OF DEATH <i>Balt. Md.</i> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4018 BARRINGTON Rd.</i> | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <i>214 S. 20th St. Kansas City, Mo.</i> | | | | | | | | | |
| 17. FATHER'S NAME (FIRST, MIDDLE, LAST) <i>Jessie White</i> | | 18. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) <i>Cora White</i> | | 19. STREET ADDRESS, ZIP CODE <i>3069 North 17th St. Kansas City, Mo.</i> | | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 21. SOCIAL SECURITY NO. <i>227-20-8584</i> | | 22. INFORMANT NAME <i>Mr. Remondice</i> ADDRESS <i>P.O. Box 413121</i> | | | | | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple cerebrovascular accident.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease.</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Multi-infarct dementia, Hypertension.</i> | | | | | | | | | |
| 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>June 24 1982</i> | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION STREET CITY OR TOWN COUNTY STATE <i>600 Light St. Balt. Md. 21230.</i> | | | | | |
| 34. I certify that (I) (this hospital) attended the deceased from <i>June 24 1982</i> to <i>July 16 1986</i> that (I) (we) last saw the deceased alive on <i>June 24 1982</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.) | | | | | | | | | |
| 35. SIGNATURE <i>George Taler, M.D.</i> | | | | 36. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 37. DATE SIGNED <i>July 17, 1986</i> | |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GEORGE TALER, M.D.</i> | | | | 39. ADDRESS <i>600 Light St. Balt. Md. 21230.</i> | | | | | |
| 40. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>BURIAL</i> | | 41. DATE <i>7-21-86</i> | | 42. NAME OF CEMETERY OR CREMATORY <i>Mt. Hope Cem.</i> | | 43. LOCATION CITY OR TOWN COUNTY STATE <i>KANSAS CITY Kansas</i> | | | |
| 44. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i> | | | | 45. ADDRESS <i>2222 W. North Ave.</i> | | 46. DATE REC'D BY REGISTRAR <i>JUL 17 1986</i> | | 47. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0-13148

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20058

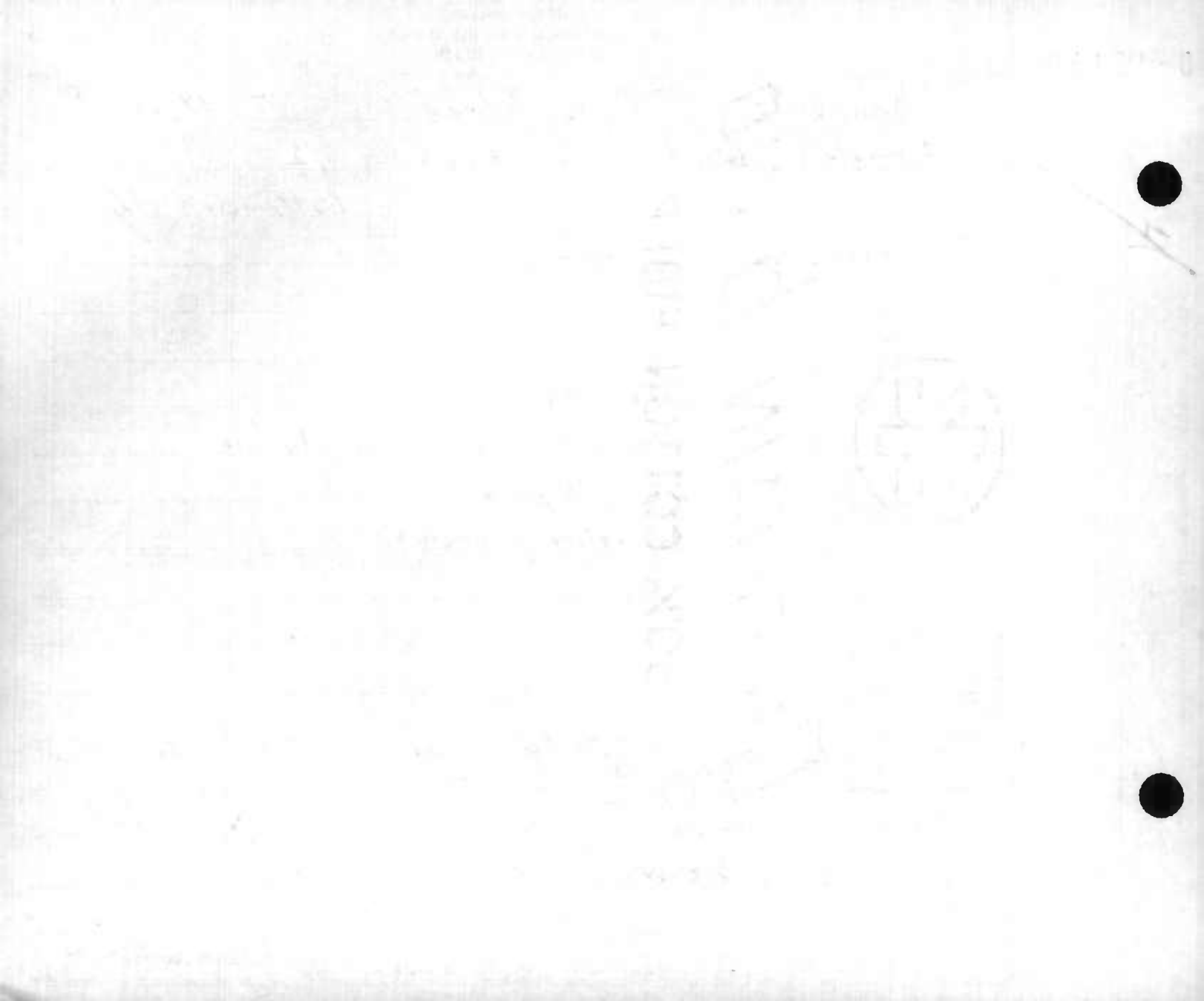
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Annabelle BELL WHITEHEAD | | | 2a. DATE OF DEATH MONTH 7 DAY 19 YEAR 86 2b. HOUR 4⁵⁰ a.m. | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST Thomas MIDDLE LAST McCardell | | 15. MOTHER'S MAIDEN NAME FIRST Carie MIDDLE LAST Duncan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO. 219-03-6595 | | |
| 17. INFORMANT Thomas McCardell | | ADDRESS 5122 Craig Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio/respiratory/vascular failure DUE TO, OR AS A CONSEQUENCE OF (b) DIC/sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration pneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/16 19 86 to 7/19 19 86 , that (I) (we) lost saw the deceased alive on 7/19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Guillermo Abesada-Terk Jr | | DEGREE MD | | 22c. DATE SIGNED 7/19/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Guillermo Abesada-Terk Jr | | 22e. ADDRESS 4 Montaigne Court #3B | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 7/23/86 | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. |
| 24. FUNERAL DIRECTOR NAME Martha Funeral Homes ADDRESS 1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.



00-13092

MICU 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REG. NO. 20059

| | | | | | | | | | |
|---|--|--|---|---|-----------------------------|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE K. WHITEHURST | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 20, 1986 | | | 2b. HOUR P 11:40 | | | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 3 2 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME IF IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) American Can. Co. | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Murphy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Green | | | 13e. STREET ADDRESS / ZIP CODE 2537 Fait Ave. 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-5467 | | 17. INFORMANT ADDRESS Reading, Pa. William H. Whitehurst 211 N. 6th St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATED DIVERTICULAR ABSCESS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 72 HOURS 48 HOURS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a RENAL FAILURE | | | | | | | | | |
| 19a. DATE OF OPERATION 7/12/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED BOWEL | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12/86 19 1986 to 7/20 19 1986 that (I) (we) last saw the deceased alive on 7/20 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ricardo Sanchez MD, MPH | | | | DEGREE MD, MPH | | | | 22c. DATE SIGNED 7/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICARDO L. SANCHEZ | | | | F7466 | | 22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE ST. BALTO, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. 21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE | |

4 27 05 555 2
SINAR, TEGUNTING
K. PIVONED

WICU

00-11192

Items 6-15 per Hosp.
FOR 7/25/86 DAD
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20060
REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) B. B. | | FIRST B. B. | | MIDDLE | LAST White Side | 2a. DATE OF DEATH MONTH DAY YEAR 11 6 86 | | 2b. HOUR 12 38 AM | |
| 3. SEX F | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 4 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS | | IF UNDER 1 YEAR MONTHS DAYS 1 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE 5310 BEAUFORT AVE. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Whiteside | | 17. INFORMANT ADDRESS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO Respiratory Arrest</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MELANOMA</u> <u>Aspiration</u> , <u>Group B-</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Shed Sepsis</u> , <u>PFC</u> | | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Rt. Pneumothorax</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> 19 <u>86</u> , to <u>1/16</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1/16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>K. Harper</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED <u>1/16/86</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KOTTA PALLI</u> | |
| 22e. ADDRESS <u>Franklin Scott Key Medical Center</u> <u>4940 Eastern Ave, Baltimore, MD 21220</u> | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u> | | 23b. DATE <u>11-9-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FSCMC</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR <u>JUN 27 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-13447

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) ALBERT L. WHITFIELD, Sr | | | 2a DATE OF DEATH MONTH DAY YEAR 7 22 86 | | | 2b HOUR 8:55 AM | | | |
| 3 SEX M | | 4 RACE B | | 5 DATE OF BIRTH MONTH DAY YEAR 5 27 29 | | 6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Providence Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b KIND OF BUSINESS OR INDUSTRY Balto Gas + Electric Co. | |
| 13a STATE Md | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET ADDRESS / ZIP CODE 3137 Timanus Lane 21207 | | | 14 FATHER'S NAME FIRST MIDDLE LAST Leroy Whitfield | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Mason | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 239-32-4531 | | 17 INFORMANT ADDRESS Albert Whitfield, Jr 94 Monmouth St Springfield Mass | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GI bleed | | | | | | | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (b) cirrhosis Liver | | | | | | | | few years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) alcoholism | | | | | | | | few years. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Possible Cardiomyopathy; left anterior + RIGHT bundle branch block | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/21 19 86 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/21 19 86 to 7/22 19 86 , that (I) (we) last saw the deceased alive on 7/22 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE M. J. Shafi | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JAVAJ M SHAFI | | | | | | 22e ADDRESS 2300 Garrison Blvd 21216 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 7/28/86 | | 23c NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue | | | | | | 25a DATE REC'D. BY REGISTRAR JUL 25 1986 | | | |
| 25b REGISTRAR'S SIGNATURE John Davidson | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

BP

43811

100-2800

Div 2

100-2800

100-2800

00-14072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 20062

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|--|----------------------------|--|
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE WIENER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/22/86 | | 2b. HOUR 6:30 PM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 1 18 03 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 83 | | 8. IF UNDER 24 HRS HOURS MIN. 6:30 | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 13. STREET ADDRESS / ZIP CODE APT. G (21209) 3004 FALLSTAFF MANOR CT | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST KALMEN ISEKOFF | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction / Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 86 , to 7/22 , 19 86 that (I) (we) last saw the deceased alive on 7/22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Sam B. Miller | | DEGREE MD | | 22c. DATE SIGNED 7/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL BENNETT MILLER | | 22e. ADDRESS SINAI HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH BETH ISRAEL | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | |
| 25a. DATE RECORDED BY REGISTRAR 7/27/86 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1000

67

1000

1000

1000

20% COTTON

00-12778

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

20063

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ANDREW WILDBERGER | | July 12, 1986 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Male | White | 10 12 1910 | 75 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | Baltimore City | MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | SILVER HOSPITAL OF BALTIMORE | | Longshoreman | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| Maryland | Baltimore | Dundalk | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | |
| Jacob Wildberger | | Not Known | | 213 Detroit Avenue 21222 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | | WW II 212-01-2637 | | William Wildberger Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) COPD | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01 July 1986 to 12 July 1986, that (I) (we) last saw the deceased alive on 11 July 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Arthur Lebson, M.D. | | MEDICAL PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Arthur Lebson, M.D. | | 3640 Fords Lane | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/16/1986 | | Oak Lawn Cemetery | |
| 24. FUNERAL DIRECTOR | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | |
| Duda Ruck Funeral Home of Dundalk, Inc. | | Baltimore | | JUL 18 1986 | |
| 25a. REGISTRAR'S SIGNATURE | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0-14190

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 20064 | |
|--|--|--|---|---|--|---|---|-----------------------------------|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| MILDRED WILDIN | | | | | 7 30 86 | | | | | 10:30AM | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | WHITE | | 6 26 20 | | 66 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 2943 Mallview Road | | | | Homemaker | | --- | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| Maryland | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2943 Mallview Rd. 21230 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST Thomas Armingner | | | | | FIRST MIDDLE LAST Theresa A. Gavin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | 219-10-1790 | | Donald E. Wildin 2943 Mallview Rd. 21230 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-27</u> , 19 <u>78</u> , to <u>7-30</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>move the body after death.</u> | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED | |
| <u>John P. Urlock Jr MD</u> | | | | | | | | | | 7/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| JOHN P. URLOCK JR MD | | | | | 1227 Washington Blvd. 21230 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | | 8/2/86 | | Crest Lawn Gar. of Mem. | | CITY OR TOWN COUNTY STATE Marriottsville Howard Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | AUG 1 1986 | | <u>John P. Urlock Jr MD</u> | | | | |

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(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 2006 | | | | |
|--|--|--|--|---|--|--|--|--------------------------------|--|------------------|-----|-------|----------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | P. |
| FLORENCE WILKINSON | | | | | | | | 7 5 86 | | | | | 2 | P. |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| FEMALE | | BLACK | | 11 - 30 - 15 | | 70 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD. |
| SOUTH CAROLINA | | USA | | | | Baltimore City | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Baltimore Md | | Luthers Hospital | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | | | | |
| MARYLAND | | USA | | BALTIMORE | | | | PALL MALL NURSING HOME | | | | | | 21215 |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| ALEXANDER EXUM | | MAGGIE LOWE | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | |
| NO | | | | DR. MORRIS WILKINSON | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF SEPSIS | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/6/86 to 7/5/86, that (I) (we) last saw the deceased alive on 7/5/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | |
| Ambachew Woreta M.D. | | | | | | 7/5/86 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | |
| AMBACHAW WORETA | | 9233 WINDING WAY, ELLICOTT CITY, MD | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | |
| BURIAL | | 7-8-86 | | KING MEMORIAL PARK | | RANDALLSTOWN | | | | | | M.D. | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| REDD FUNERAL HOME | | 5209 YORK ROAD | | JUL 11 1986 | | John A. ... | | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2006
REG. NO.

| | | | | |
|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ADDIE WILLIAMS | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 8, 1986 | | 2b. HOUR 10:32 PM |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 6 11 18 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Max Suggs | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Hardy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown | | 16b. SOCIAL SECURITY NO. 213-36-4593 | 17. INFORMANT ADDRESS Ronald Williams 2030 Harlem Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Endometrial Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (his hospital) attended the deceased from <u>6/27</u> , 19 <u>86</u> , to <u>7/8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/8/86</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | |
| 22b. SIGNATURE Edward Kasper | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/8/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD KASPER | | 22e. ADDRESS Johns Hopkins Hosp. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SP) BURIAL | 23b. DATE 7/16/86 | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md. | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1986 | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 20067

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Barbara T. Williams | | 2a. DATE OF DEATH MONTH DAY YEAR 7-7-86 | | 2b. HOUR 8⁵⁵ am | |
| 3. SEX Female | 4. RACE white | 5. DATE OF BIRTH 9/26/24 MONTH DAY YEAR 09/26/24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. | |
| 7a. PLACE OF BIRTH Ohio | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor | | 12b. KIND OF BUSINESS OR INDUSTRY Real Estate |
| 13a. STATE MD | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Bethesda | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elbert S. Towt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen --- Trainer | | 13e. STREET ADDRESS / ZIP CODE 5714 Bradley Blvd./20814 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-20-8499 | | 17. INFORMANT ADDRESS Arlington, VA 22204 Thomas N. Williams, III, 200 S. Wayne St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca. of Brain and spine DUE TO, OR AS A CONSEQUENCE OF (c) Ca. of Kidney - 1/P at nephrectomy Approximate interval between onset and death: days months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1986 to July 7, 1986 , that (I) (we) lost saw the deceased alive on July 5, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B. MATOS, M.D. | | DEGREE | | 22c. DATE SIGNED 7/7/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. MATOS, M.D. | | 22e. ADDRESS 21 CRANBROOK RD. COCKEYSVILLE MD-21030 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Berryville, VA | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Gordon | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate report filed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove embossed paper (Page 1) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate report filed.

BP

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William

Person

1/22/74

White

Baltimore City

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U.S.A.

Ohio

Real Estate

Real Estate

Shawwood Building Home

Baltimore

2114 Broadway Blvd. \50814

x

Bethesda

Montgomery

MD

Trainer

--

John

Two

2.

Albert

Arlington, VA 22204

Thomas F. Williams, III, 500 S. Wayne St.

370-80-849

no

Springville, VA

Green Hill Cemetery

burial

Joseph Gable's sons, Inc.

2130 Jackson Ave., NW, Washington, D.C. 20006

00-13781

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

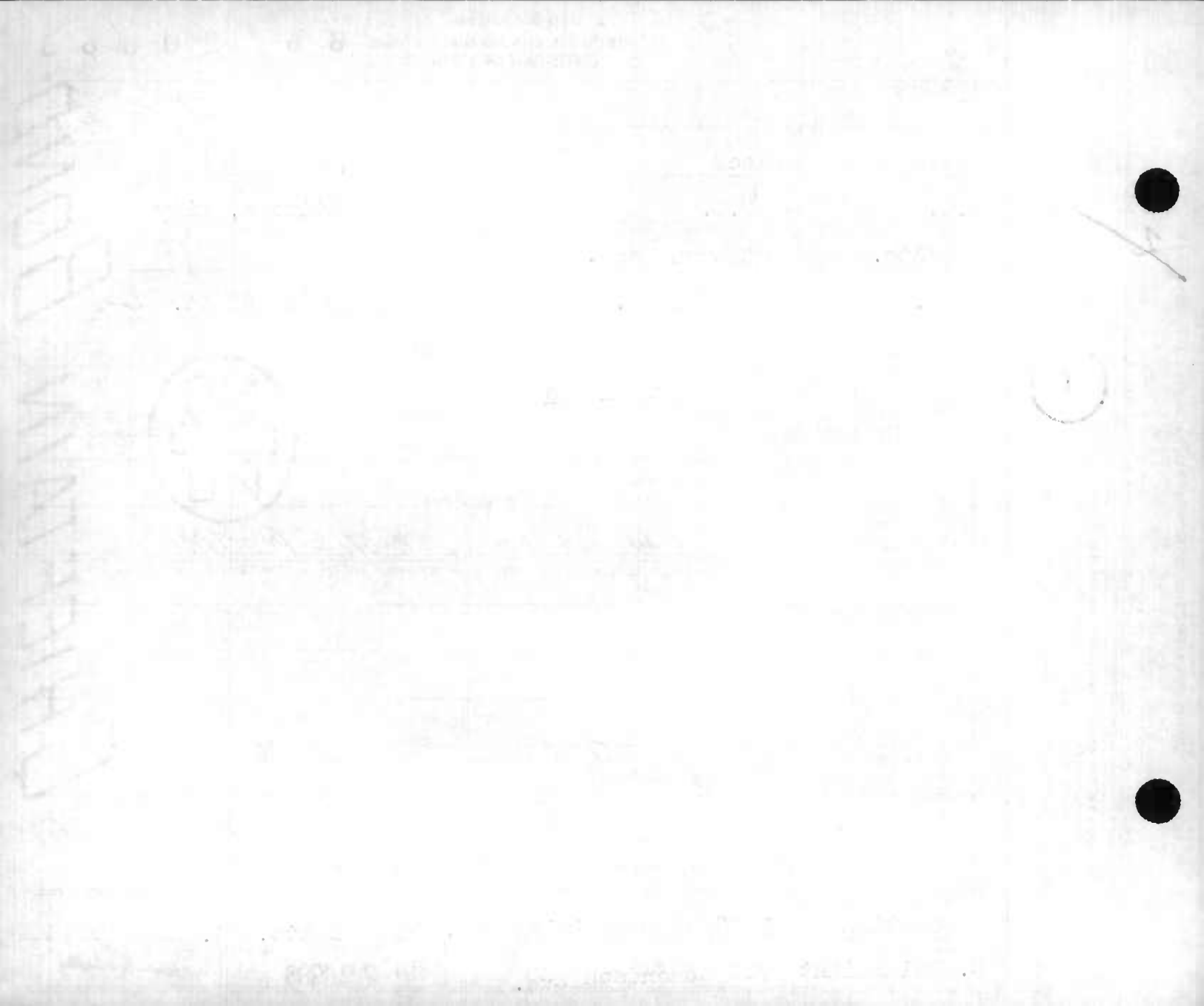
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 6 8

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) First: <i>David</i> MIDDLE: LAST: <i>Williams</i> | | | 2a. DATE OF DEATH MONTH: <i>7</i> DAY: <i>26</i> YEAR: <i>86</i> | | | 2b. HOUR <i>243</i> M | | | |
| 3 SEX <i>Male</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH: <i>6</i> DAY: <i>5</i> YEAR: <i>07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS. | | IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE <i>3313 Poplar St. 21216</i> | | | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Balto.</i> | | | | | |
| 14. FATHER'S NAME FIRST: <i>Unknown</i> MIDDLE: LAST: | | | | 15. MOTHER'S MAIDEN NAME FIRST: <i>Unknown</i> MIDDLE: LAST: | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>216-10-9891</i> | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA COLON & PROSTATE</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE: | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-23-</i> 19 <i>86</i> , to <i>7-26-</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>7-26-</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Sher A Hashmi</i> | | | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>7-26-86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SHER AFZAL HASHMI</i> | | | | 22e. ADDRESS <i>730 ASHBURTON ST 21216</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | | 23b. DATE <i>7/28/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Westview Mem. Park</i> | | 23d. LOCATION CITY OR TOWN: COUNTY: STATE: <i>Balto. Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME: <i>C. Wainwright</i> ADDRESS: <i>2700 Edmondson Ave.</i> | | | | | | 25a. DATE REC'D BY REGISTRAR <i>JUL 29 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randall</i> | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

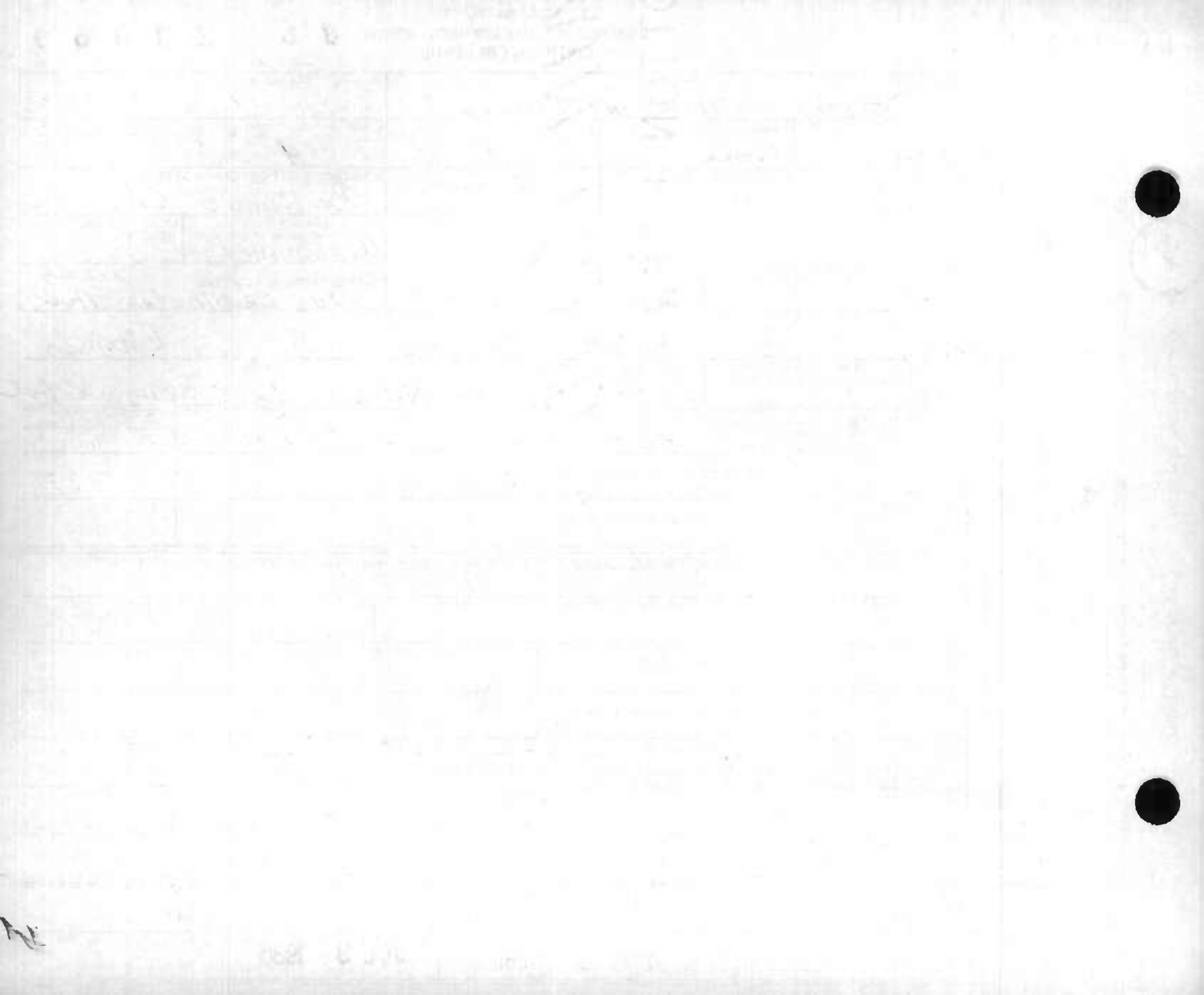
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 6 9

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy Thompson Williams | | | 2a. DATE OF DEATH MONTH DAY YEAR July 6 1986 | | 2b. HOUR 1203⁴ M |
| 3 SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 2 17 32 | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1208 Seminole Ave 21229 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry B. Knight | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Robinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-30-2828 | | 17. INFORMANT ADDRESS Victor Williams 1208 Seminole Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Lung Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1977 1982 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/5 , 19 86 , to 7/5 , 19 86 , that (I) (we) last saw the deceased alive on 7/5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J. Bonelli | | DEGREE MD | | 22c. DATE SIGNED 7/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose F. Bonelli | | 22e. ADDRESS St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/10/86 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | 23d. LOCATION CITY OR TOWN COUNTY Owings Mills MD | |
| 24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D BY REGISTRAR JUL 8 1986 | 25b. REGISTRAR'S SIGNATURE |

BP



00-12829

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20070

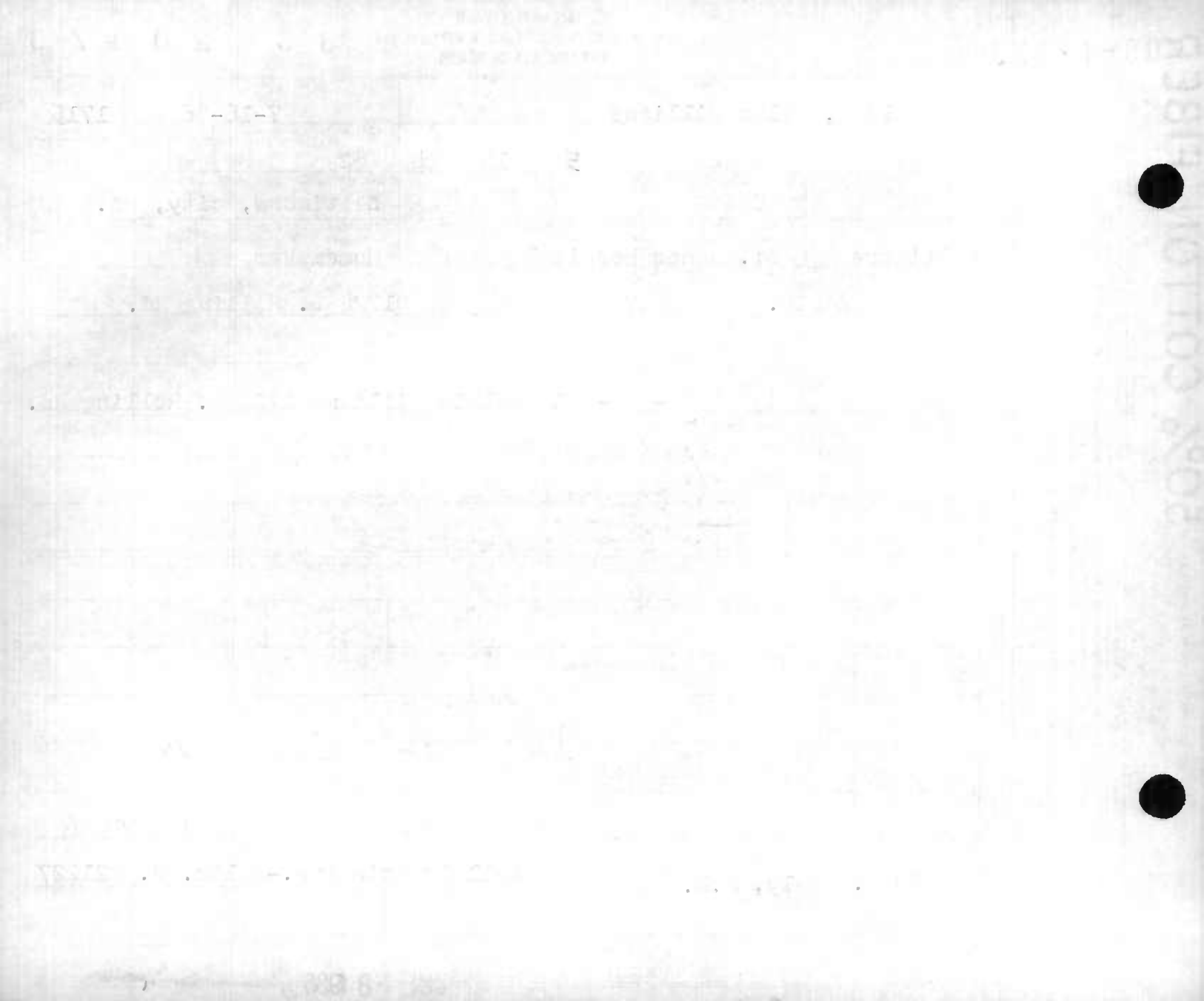
REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Eliza, Ellen Williams | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-16-86 | | 2b. HOUR 1715 M | |
| 3. SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 04 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, city, md. MD. | |
| 10 CITY OR TOWN OF DEATH baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO. 13c. CITY OR TOWN RELAY 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Baltimore, Md. 1724 S. Rolling Rd. 21227 | | | | | | | |
| 11. FATHER'S NAME FIRST MIDDLE LAST Joseph Albert Williams, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Priscilla Ireland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-32-2892 | | 17 INFORMANT ADDRESS Nellie Williams 1724 S. Rolling Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14 19 86 to July 16 19 86 , that (I) (we) last saw the deceased alive on July 16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE John C. Healy | | | | DEGREE MD | | 22c. DATE SIGNED 7/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Healy, M.D. | | | | 22e. ADDRESS 1311 Francis Ave.-Balto.Md. #21227 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/21/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR NAME ADDRESS NOTTER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JUL 18 1986 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



00-13248

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their plate number is on the back of page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

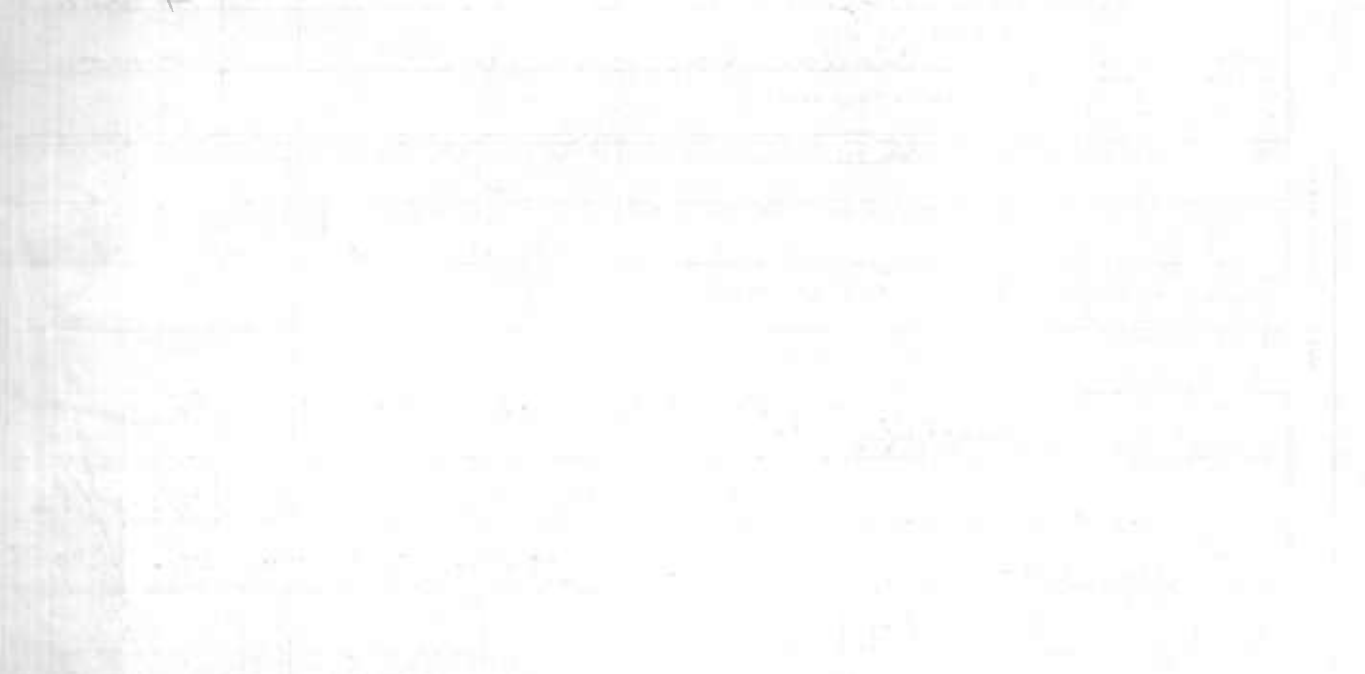
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8

20071

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERNEST | | | FIRST WILLIAMS | | | MIDDLE | | | LAST | | | 2b. DATE OF DEATH MONTH 07 DAY 22 YEAR 86 | | | 2b. HOUR 8:40 M | | |
| 3. SEX male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH 6 DAY 25 YEAR 14 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | | 8. IF UNDER 1 YRS. 1 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LR VAH | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY BA | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 835 E. Kridge Landing RD 21090 | | | | | |
| 14. FATHER'S NAME FIRST OSCAR MIDDLE WILLIAMS LAST LULA | | | 15. MOTHER'S MAIDEN NAME FIRST LULA MIDDLE CLYBURN LAST 21090 | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. 24903 9899 | | | 17. INFORMANT ADDRESS Eva Williams 835 E. Kridge Landing RD 21090 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF (b) Bladder Ca, 3 mets. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos. 6 mos. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 24 , 19 86 , to July 23 , 19 86 , that (I) (we) last saw the deceased alive on July 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Jim CITA | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/23/86 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS LR VAH 3900 Loch Raven Blvd. Balto Md | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/25/86 | | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville | | | 23d. LOCATION CITY OR TOWN Crownsville COUNTY MD STATE | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. | | | ADDRESS 110 East North Ave. | | | 25a. DATE REC'D. BY REGISTRAR JUL 24 1986 | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | | |

15005



00-15035

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 7 2

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FLOYD WILLIAMS | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/28/86 | | | 2b. HOUR 6:05 PM | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 2 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 607 Pa. Ave. 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn. | | | 16b. SOCIAL SECURITY NO. 226-14-0612 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) END STAGE CARCINOMA OF LUNGS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE L. C. CUTO DEGREE | | | | | | 22c. DATE SIGNED 7/28 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD L. CUTO | | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 7-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 5 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Tindall-Rudner | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-12038

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND.
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

20073

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FREDERICK W. WILLIAMS, Sr. | | | 2a. DATE OF DEATH MONTH 07 DAY 10 YEAR 86 | | 2b. HOUR 0838 M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH 05 DAY 05 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROC RAVEN VA HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. STATE MD | | | 13b. COUNTY BALT | 13c. CITY OR TOWN BALT | |
| 14. FATHER'S NAME FIRST Loucius MIDDLE Williams LAST Williams | | | 15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE Williams LAST Williams | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 219183183 | | 17. INFORMANT Frederick W. Williams Jr. 1718 N. Bethel | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 097 -- 0830 Died Dec 85 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION NIA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NIA | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NIA | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 July 86 , 19____, to 7 July 86 , 19____, that (I) (we) last saw the deceased alive on 7 July 86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Romanosky MD PhD | | DEGREE | | 22c. DATE SIGNED 7 July 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Romanosky | | 22e. ADDRESS LR JAMC, Alameda + LRaven BLVD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville VA. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Maryland | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 10 1986 | | | |
| 24. FUNERAL DIRECTOR NAME Wm.C. March F/H Inc. 1101 East North Avenue ADDRESS | | | | | |

BP

0-13857

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 20074

| | | | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|--|--|--|--|--------------------------|--|------------------|--|-------------|--|----------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF ESTI. DEATH MATED | | MONTH | | DAY | | YEAR | | 7b. HOUR | | | |
| Horace J. Williams | | | | | | | | 7-26-86 | | 19 | | | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 7d. HOUR | |
| Male | White | May 18, 1923 | | 63 YRS. | | | | | | 7-26-86 | | 19 | | | | | | 3:58A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 403 S. Lehigh Street | | Carpenter | | Construction | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | Baltimore | | Owings Mills | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 282 Pittston Circle | | 21117 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| John Elmer Williams | | Elizabeth Catherine Parks | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 215 12 4409 | | Bernice M. Williams | | 282 Pittston Circle | | 21117 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | GUESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| | | | | Gunshot wound of chest | | | | | | | | | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| | | approx 3:45 PM 7-26-86 | | subject shot during altercation | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | 1st. fl. kitchen | | 403 S. Lehigh St. | | Baltimore, Maryland | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED | | 7-26-86 | | | |
| ACTUAL SIGNATURE | | Margarita A. Korell, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Margarita A. Korell, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Cremation | | July 30, 1986 | | Westview Crematory | | Winters Lane, Balto. Co., Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| | | Burgee-Henss Funeral Home, Baltimore, Md. | | | | 07-20-86 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

100 3.0

100 7.0

100 7.0

0-12246

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8620075

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|-----------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Irene C. Williams | | | 2a. DATE OF DEATH 7/9/86 | | | 2b. HOUR 9 P M | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH Aug. 19, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal | | 12b. KIND OF BUSINESS OR INDUSTRY School | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 418 Edgewater Road 21122 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter A. Schramm | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Schramm | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - - | | 17. INFORMANT ADDRESS Mr. Walter Williams 418 Edgewater Rd. 21122 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia ARDS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) organ failure.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: old age

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION 5/28/86 6/26/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED rectal volvulus, colon mass | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE <u>Gustavo A. Canzales</u> | | | | DEGREE M.D. | | 22c. DATE SIGNED 7/9/86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) GUSTAVO A. CANZALES, M.D. | | | | 22e. ADDRESS Union Memorial Hospital | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY Greenwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, N. Y. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Rodriguez</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some words like "for", "the", "and" are faintly visible.]



00-12685

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8620076
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) WILLIAMS JACQUELINE WILLIAMS | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 12, 1986 | | 2b. HOUR 2 P.M. | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 01 05 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. CITY OR TOWN BALTO. CITY | | 13c. STREET ADDRESS / ZIP CODE 831 GEORGE ST 121201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JUNIUS HOLCOMB | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL CAMBELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-16-0996 | | 17. INFORMANT ADDRESS Betty Williams 831 George Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal renal failure</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Hypertension</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/8</u> 19 <u>86</u> , to <u>7/12</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Stephen Zemel MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>7/12/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen Zemel MD</u> | | | | 22e. ADDRESS <u>22 S. Greene St</u> <u>Balto MD 21201</u> <u>Div. of Nephrology</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 7/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 17 1986 | | | |

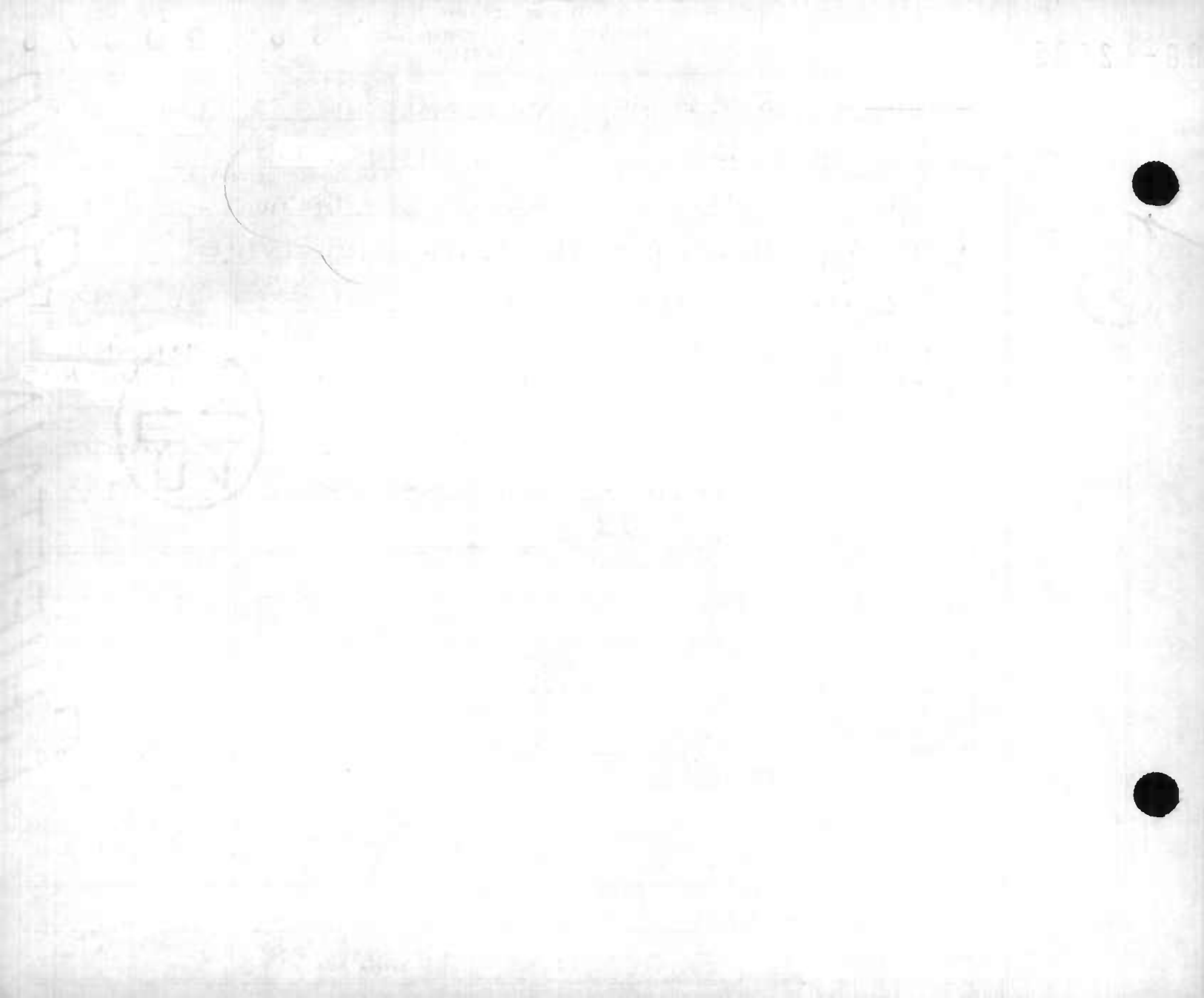
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-14139

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 20077
REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Louis L. Williams | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-22-86 | | | 2b. HOUR 7:10 P.M. | | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 / 10 / 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md 13b. COUNTY Balto 13c. CITY OR TOWN BALTO. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 202 Woodlawn Ave. 21219 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Williams | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Thornton | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 213-07-7593 | | |
| 17. INFORMANT Mrs. Earl Kennard | | | ADDRESS 3420 Courtleigh Dr. 21267 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver Cancer (Primary versus metastatic) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 16 , 19 86 , to July 22 , 19 86 , that (I) (we) last saw the deceased alive on July 22 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE KLW - Carl | | | DEGREE | | | 22c. DATE SIGNED 7-22-86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Wisner - Carlson | | | 22e. ADDRESS FSK | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK BY) Burial | | | 23b. DATE 7-28-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne Co. Md | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

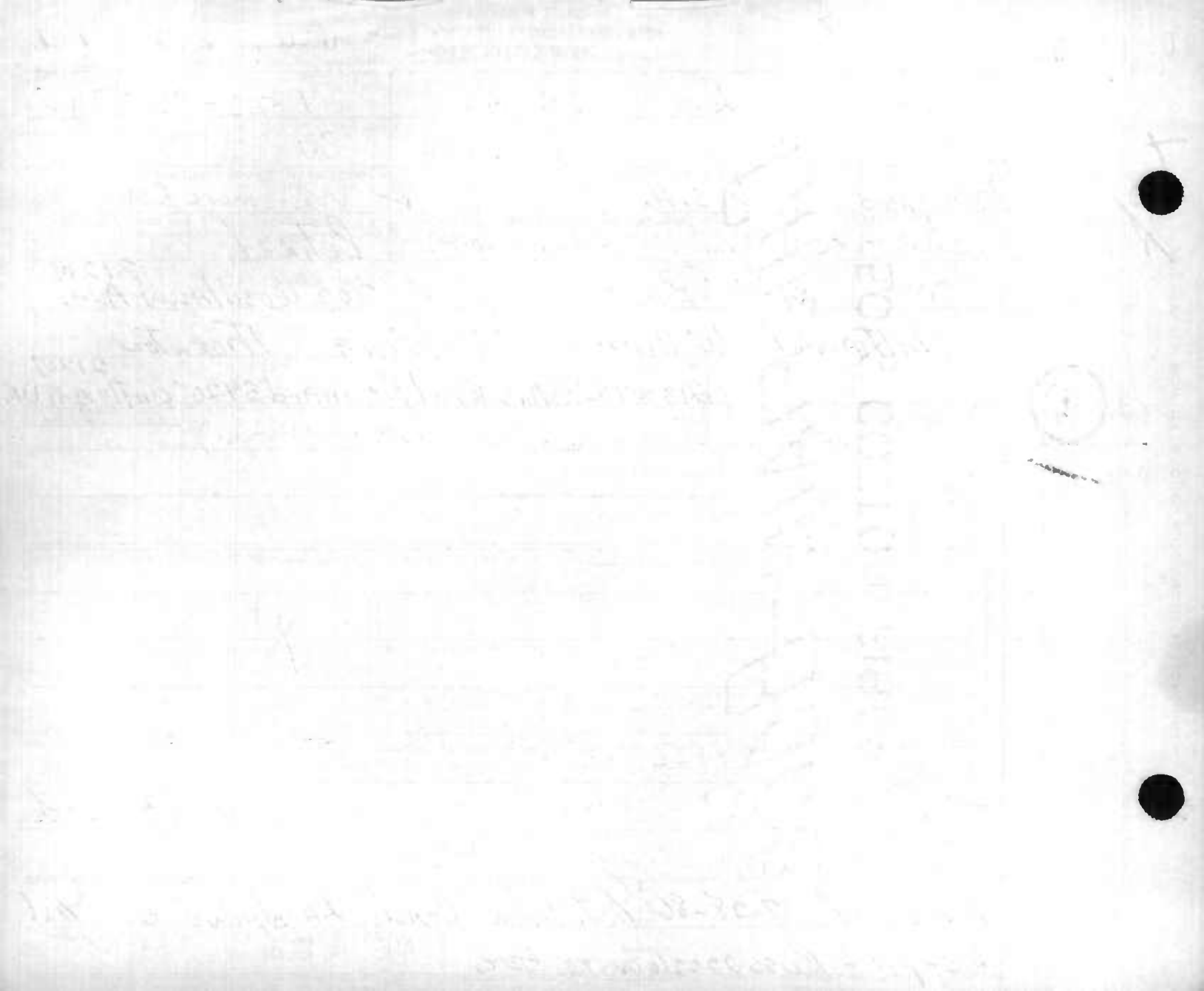
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial/cremation permit. Their release removes the responsibility for the death certificate from the funeral director and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-13511

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

2007

8

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lola M. Williams | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-23-86 | | 2b. HOUR 7:46 M |
| 3. SEX F | 4. RACE BR | 5. DATE OF BIRTH MONTH DAY YEAR 07 24 33 | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social worker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS & ZIP CODE 506 Mount St., 21227 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Harris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Naomi house Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-0076 | | 17. INFORMANT ADDRESS ANNIE HARRIS 21227 101 Polianski Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac arrest collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/15/86</u> to <u>7/23/86</u> , that (I) (we) lost saw the deceased alive on <u>7/15/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Willie</u> | | DEGREE MD | | 22c. DATE SIGNED 7/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willie | | 22e. ADDRESS Home 440 Eastern Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-28-86 | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. | | 23d. LOCATION BALTO COUNTY MD. |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons | | | ADDRESS 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR JUL 25 1986 |
| | | | 25b. REGISTRAR'S SIGNATURE <u>J. A. Morton</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified or called.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

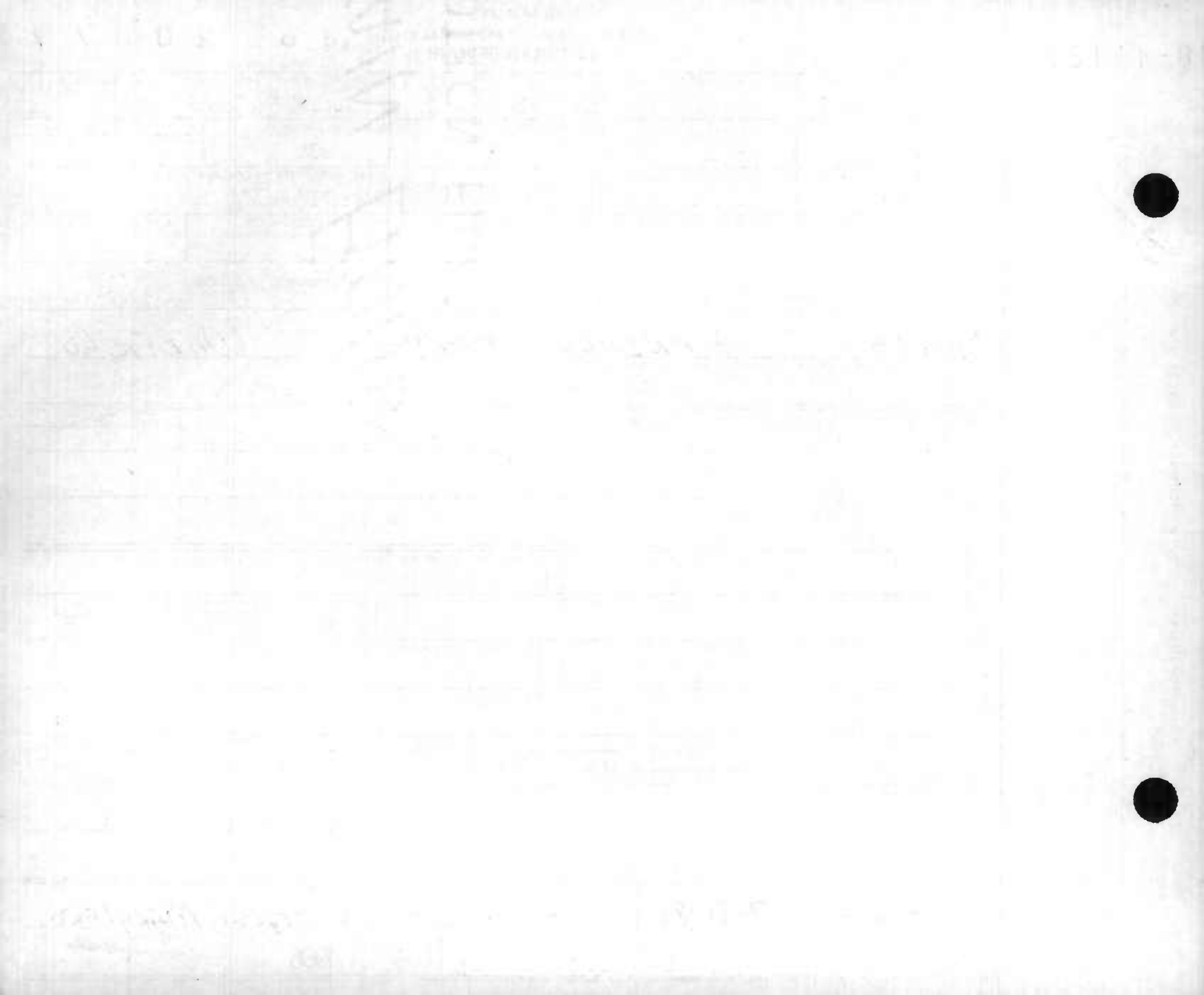
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, listed on by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 272 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 2 0 0 7 9 REG. NO. | |
|--|--|---|--|---|--|--|---|--|----------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAUDE WILLIAMS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1986 | | | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 12 92 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 808 WHITELOCK STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Apt. 12A 727 Druid Park Lake Drive 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES - RANDALL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY WARFIELD | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 213-54-0115 | | 17. INFORMANT ADDRESS Darlene Bailey 808 Whitelock Street | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Lung Metastatic DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10 , 19 86 , to 7/26 , 19 86 , that (I) (we) lost saw the deceased alive on 7/10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. P. H. H. H. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/28 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. P. H. H. H. | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY Cokesberry Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE PORT DEPOSIT, MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME BROWN/Thompson F. H. | | | | | | ADDRESS 1913 W. BALTO. ST. | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the container provided for the use of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. If item 21 is marked or item 18 shows any injury, the medical examiner must be notified and the certificate must be signed by the medical examiner.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 6 20080 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELSON WILLIAMS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-10-86 | | | 2b. HOUR 10-45 PM | |
| 3. SEX M | | 4. RACE B. | | 5. DATE OF BIRTH MONTH DAY YEAR 1 12 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WARRENTON NC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) No Charles General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer | | 12b. KIND OF BUSINESS OR INDUSTRY Lawyer | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1705 Rosevale St 21216 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Austin Williams | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leathin 21216 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 226-22-0786 | | 17. INFORMANT ADDRESS Walter Williams 1705 Rosevale St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis and congestive cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arterio-sclerotic Cardio-vascular diseases. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/16/1986 to 7-10-1986 that (I) (we) last saw the deceased alive on 7-10-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R.M. Shah, M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7-10-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH, M.D. | | | | | 22e. ADDRESS North Charles General Hospital Baltimore, MD 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 7-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY St Calvary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD 21228 | | | |
| 24. FUNERAL DIRECTOR NAME Marlene Adams 636 N 9th Ave St | | | | | | 25a. DATE REC'D. BY REGISTRAR 11/14/1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson | |

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WELSON WICKHAM

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00-12837

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM NO. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20081

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILSON | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 DAY 16 YEAR 1986 HOUR 7 MIN 50 | | | | | | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH 11 DAY 22 YEAR 50 | | 6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH 7 DAY 16 YEAR 1986 HOUR 7 MIN 50 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? u.s.a. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1822 N. Caroline Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/a | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1822 North Caroline Street | | | | | | | | | |
| 14. FATHER'S NAME FIRST Wilson MIDDLE LAST Williams | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Georgia MIDDLE LAST Stratten | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 217543267 | | 17. INFORMANT ADDRESS Mamie Brooks 1822 North Caroline Street | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 7-16-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street Balto., Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (5a-5f) Burial | | | | 23b. DATE 7/21/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn | | | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME WM.C. March F/H Inc. ADDRESS 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

18005

13041-00

20% COTTON FIBER

WINDMILL BRAND



00-13861

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--------------------------------------|--|--|-----------------|-------------------|-----------------|---|--|--------------------------------|--|--|--|------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 86 20082 | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| KENNETH E. WILLIAR | | | | | JULY 28, 1986 | | | | | 1:00A M | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | | | | | |
| Male | | | White | | Dec. 3, 1926 | | | 59 Yrs. | | | MONTHS DAYS | | HOURS MIN. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | |
| Mt. Airey, Md. | | | U. S. A. | | | | | BALTIMORE CITY MD. | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION | | | | | | | | | | | | | | |
| BALTIMORE | | | THE JOHNS HOPKINS HOSPITAL | | | | | | | Supervisor- Off.-Sugar Ref. | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | |
| Md. | | | | | | | | | | --- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21224. 37 S. Ellwood Avenue | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Ralph | | | | | Williar | | | | | Genevieve | | | | | Nail | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | | | | | | | | | |
| Yes. | | | | | WW 11 | | | | | 219-20-3250 | | | | | Mrs. Mildred M. Weese-1213 Broening Hwy. Md. 21224. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | CARDIORESPIRATORY ARREST | | | | | 10 MIN. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | SEPSIS | | | | | 12 HRS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Chr Obstructive pulmonary Disease | | | | | 1 Month | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | | | | | | | | | | | | | | | |
| CENTRAL PONTINE MYELINOLYSIS, HYPONATREMIA | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 7a. AUTOPSY? | | | | | 7b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 7/1/86 | | | | | CECAL VOLVULUS | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21a. INJURY OCCURRED | | | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | | | 21c. LOCATION | | | | | | | | | | | | | | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | STREET | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30, 1986, to 7/28, 1986, that (I) (we) last saw the deceased alive on 7/28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | | |
| | | | | | | | | | | Scott Carnivale MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 7/28/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| SCOTT CARNIVALE | | | | | | | | | | JOHNS HOPKINS HOSPITAL | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | | | | | | |
| Burial | | | | | 7/31/86 | | | | | Oak Lawn Cemetery | | | | | Baltimore, Md. 21224 | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR | | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | |
| John A. Moran, Inc. Funeral Home | | | | | | | | | | JUL 30 1986 | | | | | John A. Moran | | | | | | | | | |
| 3000 E. Baltimore Street, Balto., Md. 21224 | | | | | | | | | | | | | | | | | | | | | | | | |

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WIRING

RECEIVED

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 20083
REG.-NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUTH | | FIRST WILLIS | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 7-7-86 | | 2b. HOUR 7:55 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7-23-14 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.-A Va. | | 9. CITIZEN OF WHAT COUNTRY? U.S.A | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen Hosp. | | 14. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 16. KIND OF BUSINESS OR INDUSTRY Nurse | |
| 17. STATE MD | | 18. COUNTY Baltimore | | 19. CITY OR TOWN Baltimore | | 20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21. STREET ADDRESS / ZIP CODE 4220 Morrison Ct., 21226 | |
| 22. FATHER'S NAME FIRST MIDDLE LAST DAVID E ZRA SMITH | | 23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA BELCHER | | 24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 25. SOCIAL SECURITY NO 232-28-8264 | | 26. INFORMANT Mary C. Hill | |
| 27. ADDRESS Balto., Md. 21226 | | 28. ADDRESS 4200 Morrison Ct., | | 29. ADDRESS Balto., Md. 21226 | | 30. ADDRESS 4200 Morrison Ct., | | 31. ADDRESS Balto., Md. 21226 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (b) SEVERE HEART Disease DUE TO, OR AS A CONSEQUENCE OF: (c) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | |
| 19. DATE OF OPERATION | | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE Michael Kazak | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK | | 22c. ADDRESS 3001 South Hanover St. | | 22d. DATE SIGNED 7-7-86 | | | |
| 22e. SIGNATURE Michael Kazak | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK | | 22g. ADDRESS 3001 South Hanover St. | | 22h. DATE SIGNED 7-7-86 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/11/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Homes | | 24a. ADDRESS Balto., Md. 21225 | | 24b. ADDRESS 237 E. Patapsco Ave | | 24c. DATE REC'D. BY REGISTRAR JUL 10 1986 | | 24d. REGISTRAR'S SIGNATURE John Anderson | |

MEDICAL CERTIFICATION

9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

POST OFFICE (1211) 107100 2003

X

0-12342

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove to the proper papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signed, any injury, or other traumatic event, the medical examiner must be notified.

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 0 0 8 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY E WILLOUGHBY JR | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 11, 1986 | | 2b. HOUR 3:45 P M |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4 9 1933 | 6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry E. Willoughby | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Yacucci | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | 16b. SOCIAL SECURITY NO. 218-28-3120 | 17. INFORMANT ADDRESS Mrs. Rita Krieger 6968 Marsue Dr. Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis into Trachea DUE TO, OR AS A CONSEQUENCE OF (b) metastatic sarcoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min one year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 7/11 19 86 , to 7/11 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 7/11 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE Robert Udelman M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 7/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Udelman M.D. | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-15-86 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME Eline Funeral Home | | ADDRESS 11824 Reisterstown Rd. | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | 25b. REGISTRAR'S SIGNATURE |

BP

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00-12479

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20035

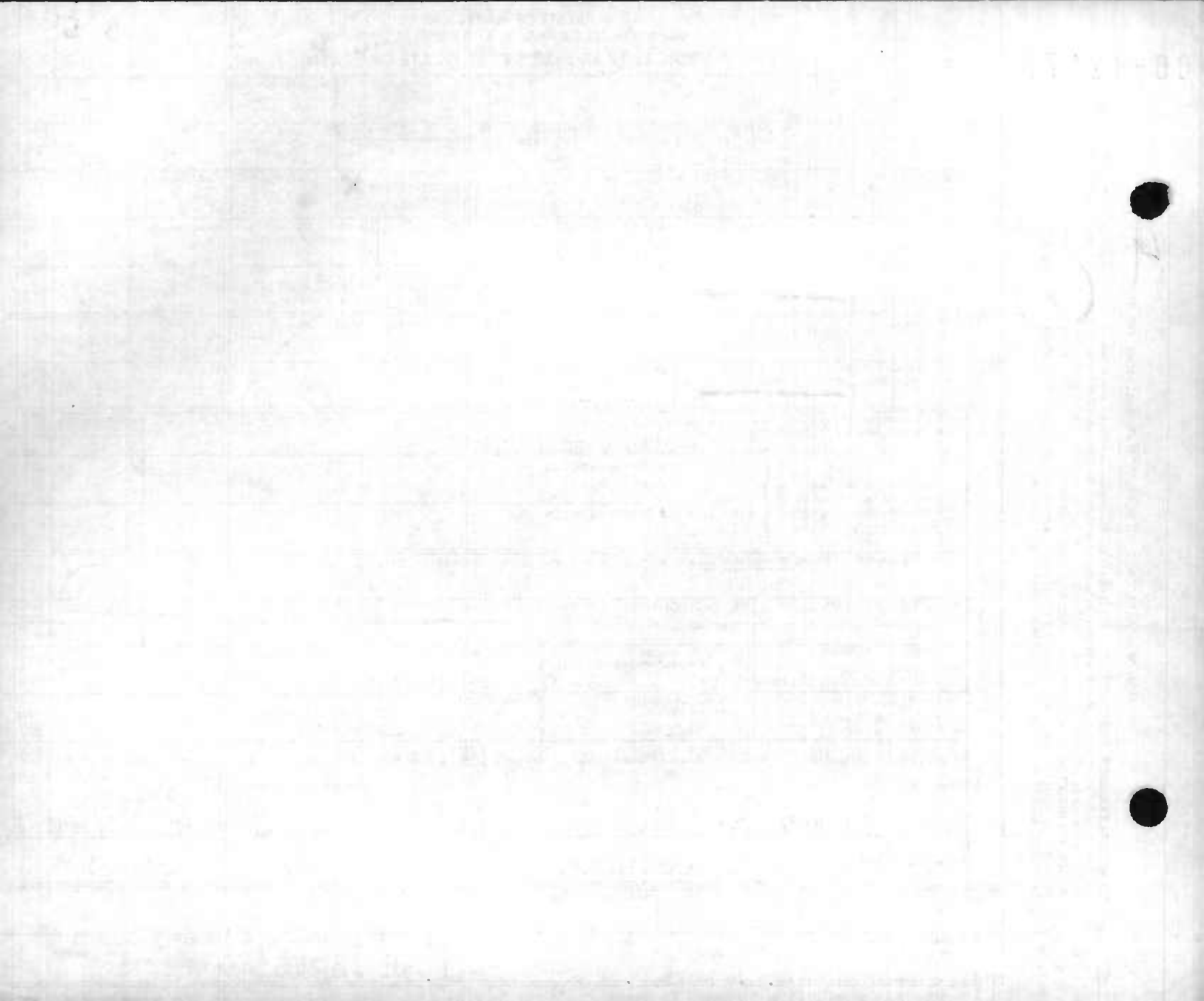
| | | | |
|---|---|--|--|
| 1- STATE REGISTRAR | | FOR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | |
| Anthony Wilson | | | |
| 2a. DATE KNOWN OF DEATH | MONTH DAY YEAR | 2b. HOUR | |
| 7 | 9 19 86 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| MALE | BLACK | 05-10-64 | 22 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| BALTIMORE, MD. | USA | | Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | University Hospital | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| MARYLAND | | BALTIMORE | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | |
| PEDRO WILSON | MOZELL WILSON | 218-92-3808 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| NO | 218-92-3808 | MOZELL WILSON 1114 WICKLOW RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wound of neck</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR <u>10:32</u> MONTH <u>7</u> DAY <u>8</u> YEAR <u>86</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | bar | 4609 Edmondson Ave. Balto. MD. | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | TITLE (SPECIFY) | DATE SIGNED | |
| <i>Margarita A. Korell</i> | M.D. Assistant | 7/9/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | ADDRESS | BALTIMORE, MARYLAND | |
| Margarita A. Korell, M.D. | 111 Penn St. | Balto. MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | 07-15-86 | CEDAR HILL CEMETERY | BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| BROWN/THOMPSON F.H. | 1913 W. BALTIMORE ST. | JUL 15 1986 | <i>John W. Thompson</i> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



00-12820

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 20080
REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Wilson | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 13 86 | | | 2b. HOUR 12:07 AM | | | | |
| 3. SEX male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 27 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto city MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | |
|---|--|--|---|--|------------------------------------|--|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | 13c. COUNTY Balto. | | 13d. CITY OR TOWN Balto. | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS - ZIP CODE 2824 Ellicott Dr. 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Wilson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE GREEN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II | | | 16b. SOCIAL SECURITY NO. 215-16-9009A | | | 17. INFORMANT ADDRESS Mrs. Genevieve Wilson 2824 Ellicott Dr. 21216 | | | | |

CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

| | | | |
|--|--|---|--|
| IMMEDIATE CAUSE (a) Cardiac Arrest | | DUE TO, OR AS A CONSEQUENCE OF (b) Fluid Electrolyte Imbalance | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure - Uremia | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Senile dementia / DSHD.**

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 86 , 19 85 , to July , 19 86 , that (I) (we) lost saw the deceased alive on 13 July , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Curtis Davis | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 14 July | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CURTIS DAVIS | | | | 22e. ADDRESS Bon Secours Hosp 21223 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-17-86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Mt Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | JAMES WILSON | | 2a. DATE OF DEATH | | 7/26/1986 | | 530 M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH 10-6-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85yrs. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? AMERICA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE | | 10. CITY OR TOWN OF DEATH BALTIMORE | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KEY CIRCLE HOSPICE | | 12a. USUAL OCCUPATION (TYPE OF WORK AT MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | | 13a. STREET ADDRESS / ZIP CODE PLAZA MANOR NURSING HOME | | 13b. COUNTY BALTIMORE | |
| 14. FATHER'S NAME UNKNOWN | | 15. MOTHER'S MAIDEN NAME UNKNOWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | 16b. SOCIAL SECURITY NO. 219-54-3748 | | 17. INFORMANT DONALD SCOTT CROWNSVILLE STATE HOSP. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 degenerative dementia | | 19a. DATE OF OPERATION several years | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 22a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22b. SIGNATURE E. Ellsworth Cook M.D. | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22c. DATE SIGNED 7-28-86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Ellsworth Cook M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lansdown, A.A. Md. | | 24. FUNERAL DIRECTOR Charles A. Rice FSPA 1300 Eutaw Pl. | |
| 25a. DATE REC'D. BY REGISTRAR AUG 13 1986 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. REGISTRAR'S NAME [Name] | | 25d. REGISTRAR'S ADDRESS [Address] | | 25e. REGISTRAR'S PHONE [Phone] | |



STANDARD

00-13104

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 0 0 8 8
REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST JULIA VIOLA ROBINSON WILSON <i>Julia WILSON</i> | | 2. DATE OF DEATH MONTH DAY YEAR July 13, 1986 <i>7-13-86</i> | | 3. HOUR 10:45 AM <i>10:45 AM</i> | |
| 3. SEX Female <i>F</i> | | 4. RACE Black <i>B</i> | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 15, 1989 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 <i>96</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, <i>Balti' ut</i> MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Glenarden | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 7911 Tyler Street, (20706) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Robinson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Porter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-22-6705 | | 17. INFORMANT 7911 Tyles Street, Glenarden, Sarah M. Smith (daughter) Maryland | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Shock. Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) *Aspiration pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/28</i> 19 <i>86</i> to <i>7-13</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>7-13</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Julia T. Dusing</i> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-13-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | | | 22e. ADDRESS LUTHERAN HOSPITAL | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 07/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, P.G.Co. Maryland | |
| 24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Georgia Ave. NW; Washington, DC 20011 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

(A)

200% COLLECT



00-11384

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 0 8 9

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RICHARD Woodbury WILSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 02 86 | | | 2b. HOUR 02 10^A | | | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 2 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE MD. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2006 E. Biddle Street 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Wilson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Romona Hall | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-60-7106 | | 17. INFORMANT ADDRESS Linda Wilson 1342 E. Fayette Street | | | | | |
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral infarcts. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococcus endocarditis. DUE TO, OR AS A CONSEQUENCE OF (c) I.V. drug abuse | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/21 19 86 to 7/2 19 86 , that (I) (we) lost saw the deceased alive on 7/1 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Jim Cha | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/2/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES CHA | | | | | | 22e. ADDRESS 3900 LOCH RAVEN BLVD, 21218 BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 7/7/86 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 3 1986 | | 25b. REGISTRAR'S SIGNATURE John... | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay from the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

UNION MILITARY

RECEIVED 1863

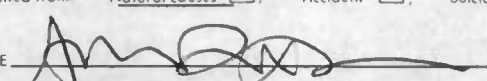
0-12647

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20090

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) HOMER S. WIMER | | | 7a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 11 86 | | | 7b. HOUR M 3:34 P | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 14 26 | 6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 11 86 | | 2d. HOUR M 3:34 P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fred Wimer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Warner | | 17. INFORMANT Mrs. Oddie Wimer, 3512 Elliott Street, Baltimore, Md. 21224 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean | | 16c. SOCIAL SECURITY NO. 236-36-1700 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE  | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 7-12-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |

MEDICAL CERTIFICATION

| | | | |
|---|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-15-86 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1986 |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY FURTHER ACTION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, CERTAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

CO 101 11888

Spes

17801-0



00-13280

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5620091

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|------------------------------------|--|--|--|-------------------------------|--|---|--|--|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| Ora | | | | M. Thompson | | | | Winchester | | | | 7 21 1986 | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS) LAST BIRTHDAY | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | | |
| female | | black | | 12 22 30 | | 55 YRS. | | | | | | 7 21 1986 | | | | 9:23A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Va | | | | U S A | | | | | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Sinai Hospital | | | | | | | | Domestic | | | | M & G Janitoria | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| Md | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 3710 Woodbine Avenue 21207 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| William Thompson | | | | Ida Gilliam | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | | 231-36-5574 | | | | Edward Thompson 727 E. 224th Bronx N.Y. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Thoracic & Abdominal injury</u> | | | | | | | | | | | | | | | | | | | |
| 7 882 | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | 8:15xx 7 21 1986 | | | | Subject fell from balcony | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | home | | | | 3710 Woodbine Ave, Balto. MD. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | | | | | |
| | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | 7/21/86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St. Balto.MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | | COUNTY STATE | | | |
| Burial | | | | 7/26/86 | | | | Green Cemetery | | | | Blackstone | | | | Va | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| March Funeral Home West 4300 Wabash Avenue | | | | | | | | | | | | JUL 23 1986 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card containing page 1 and 2 and place in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 2 0 0 9 2 | |
|---|--|--|--|---|--|--|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CRYSTAL B. WISE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-11-86 | | 2b. HOUR 6:35 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 14 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 0 MONTHS 6 DAYS 28 | | IF UNDER 1 YEAR IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL Balto. Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE MD. | | 13b. COUNTY --- | | 13c. CITY OR TOWN BALTO. | | 13e. STREET ADDRESS / ZIP CODE Balto. 21230 203 W. MCCOMAS ST. Md. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Milton J. Keller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN R. Wise | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Wise HOSP. RECORD Kathryn, Same as above | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPULMONARY DYSPLASIA DUE TO, OR AS A CONSEQUENCE OF (b) HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURITY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH LIFE | | | |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 85 , to 7-11 , 19 86 , that (I) (we) lost the deceased alive on 7-11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ronald L. Gutberlet, M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 7/11/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD L. GUTBERLET | | | | | | 22e. ADDRESS MERCY HOSP. - BALTO MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/15/1986 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dyke, Green Co. Va. | | | |
| 24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 25b. REGISTRAR'S SIGNATURE | | | | | |

BP



00-14217

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cert. amended by M.E. 9/3/86 dad
 FOR
 1- STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

20093

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|----------------|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY LOUIS WISE | | | 2a. DATE OF DEATH MONTH DAY YEAR July 29 86 | | | 2b. HOUR 12:30 P.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 29 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTIMORE MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEVELOPER | | 12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | | |
| 13a. STATE Md | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM WISE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXXX UNKNOWN XXXXXX | | | 13e. STREET ADDRESS / ZIP CODE 3201 OLD POST DR | | | APT. 1 (21208) |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 218-01-4006 | | 16c. DANCED J WISE 8536 BRISTOL RD. RANDALLSTOWN MD XXXXXXX XXXX XXXXXXXXXXXXXXXXXXXX RANDALLSTOWN MD 21133 9520 COUNTESS DR | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) SUBDURAL HEMATOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/7/86 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fell and struck head | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3201 Old Post Dr. Baltimore, Md. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 27, 19 86, to July 29, 19 86, that (I) (we) lost saw the deceased alive on July 29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. Keren M.D. | | | | Cert. approved by Dr. A. Dixon, M.E. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RON KEREN | | | | 22e. ADDRESS 9320 Countess Dr OWINGS HILLS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 7/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESD | | 23d. LOCATION RANDALLSTOWN BALTO MD STATE | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a. DATE REFILED AUG 5 1986 | | | | | |

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HILL COUNTRY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20094
REG. NO.

1. FOR
STATE
REGISTRAR

00-12573

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Judith Wise | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-11-86 | | 2b. HOUR MIN 1155 P M |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 3 5 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 3-5 ? MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balt 13c. CITY OR TOWN Balt. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3201 Old Post Dr. APT. 1 (21201) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sol SENKER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEULAH HERMAN | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 216-46-7390 | 17. INFORMANT ADDRESS DAVID J. WISE 8536 BREST RD. (21133) RANDALLSTOWN, MD. | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular asystole DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction (presumptive) DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic vessel disease (presumptive) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1a**

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| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10/86 10PM 19 1986 , to 7/12 1AM 19 86 , that (I) (we) lost saw the deceased alive on 7/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Rick Martin MD | | DEGREE MD | 22c. DATE SIGNED 7-12-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICK A MARTIN MD | | 22e. ADDRESS SINAI HOSPITAL OF BALT. | |

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|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 7/13/86 | 23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESD | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, MD. BALTO., COUNTY |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | 25a. DATE REC'D BY REGISTRAR JUL 16 1986 | 25b. REGISTRAR'S SIGNATURE <i>Jana Davidson-Gonzalez</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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2004 COLLEGE BIRTH

CHRYSTIE

10/10/04



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00-13808

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20095
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEO WISNIEWSKI WISNIEWSKI | | 2a. DATE OF DEATH MONTH DAY YEAR 07 24 86 | | 2b. HOUR 2⁵³ AM |
| 3. SEX MALE | 4. RACE CAUC. | 5. DATE OF BIRTH MONTH DAY YEAR 3 22 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RET | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH WISNIEWSKI | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE SUFCZYNSKI | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 217-03-1697 | | |
| 17. INFORMANT ADDRESS MRS HELEN MAJKA 2818 DILLON ST. | | | | |

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| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
thrombophlebitis of leg

| | | | |
|--|---|--|--|
| 9a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21e. PLACE OF INJURY | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (this hospital) attended the deceased from **7/17**, 19**86**, to **7/24**, 19**86**, that (I) (we) last saw the deceased alive on **7/24**, 19**86**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | |
|---|------------------------------------|
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Lee Kleiman | 22c. DATE SIGNED 7/24/86 |
| 22d. ADDRESS Mercy Hospital | |

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|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | 23b. DATE 7/28/86 | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. |
| 24. FUNERAL DIRECTOR NAME Kaczorowski Funeral Home | | 25a. DATE REC'D BY REGISTRAR JUL 29 1986 | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please deliver this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

U. S. A.

W. J. L. W.

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U. S. A.

00-14274

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20096

| | | | | | | | | | |
|---|------------------|--|-------------------------|---|--------------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Christopher J.J. Witteman | | | | 2a. DATE KNOWN OF DEATH ESTIMATED XX 7-30 19 86 | | | | 2b. HOUR 7:54 AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 10 19 1899 | 6. AGE (IN YEARS) 86 | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS. YRS. | 2c. DATE PRONOUNCED DEAD 7-31 19 86 | | 2d. HOUR 7:54 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 907 East 37th Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Customs | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 13a. STATE Maryland | | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 907 E. 37 th St. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Witteman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Schaefer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 1 yes | | | | (IF YES, GIVE WAR OR DATES) WW 1 | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Marguerite M. Langmann | | | | ADDRESS Apt. T 21218 2 W. University Pky | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 4 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 20097

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY W. WOLF | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-29 86 2050 | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 26 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 223 S. Calhoun Street | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Man | | 12b. INDUSTRY Tas-T-Nut Co. | | 13a. STREET ADDRESS / ZIP CODE 223 S. Calhoun Street 21223 | |
| 13b. STATE Maryland | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Max Wolf | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Smith | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII | |
| 16b. SOCIAL SECURITY NO. 219-18-8049 | | 17. INFORMANT Wanda L. Semies | | ADDRESS 7509 Patapsco Dr. 21784 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of the esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>distal esophageal stricture</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hepatitis & renal failure</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART I (b) <i>ASCVD with cardiovascular disease & aortic atherosclerosis</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF OTHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/29/86</i> to <i>6/30/86</i> that (I) (we) last saw the deceased alive on <i>6/29/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE <i>Charles S. Angell</i> | | DEGREE M.D. | | 22c. DATE SIGNED <i>6/30/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Angell | | 22e. ADDRESS 611 Park Avenue | | 22f. ADDRESS 611 Park Avenue | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland | | 23e. DATE REC'D. BY REGISTRAR JUN 30 1986 | | 23f. REGISTRAR'S SIGNATURE <i>John Davidson-Henderson</i> | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | ADDRESS 4107 Wilkens Ave. | | 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) page 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner will be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. The medical examiner must be notified if the deceased was a patient in a hospital, nursing home, or other institution. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 86 20098 | |
|--|--|---|---|--|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) SARAH WOLF | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 22 86 | | | 2b. HOUR 11 P.M. | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 11 11 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. CITY OR COUNTY OF DEATH BALTIMORE CITY OF BALTO MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL, BALTIMORE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY CLOTHING | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, ZIP CODE SURREY 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MORRIS WOLF | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARNA KOMPANAITZ | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | |
| 16a. SOCIAL SECURITY NO. 006-11-2943 | | | 17. INFORMANT MRS. LILLAIN LASNIK | | | 17a. ADDRESS 7030 SURREY DR. 21215 BALTIMORE, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) INTRACRANIAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-17 19 86 , to 7-22 19 86 , that (I) (we) last saw the deceased alive on 7-22 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Sabine Ross, MD DEGREE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SABINE ROSS, MD | | | | | | 22e. ADDRESS SINAI HOSPITAL, BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY TIFEREETH ISRAEL CEM | | 23d. LOCATION ROSEDALE BALTO MD | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rosen | | | |

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00-12598

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20099

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vercu Wolinski | | 2a DATE OF DEATH MONTH DAY YEAR 8 6 7-14-86 | | 2b HOUR 12:15 AM | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 4-17-23 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | |
| 13a STATE MD. | | 13b COUNTY East Baltimore | | 13c CITY OR TOWN Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Fales | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Mattern. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215120896 | | 17 INFORMANT Chart. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6-27-</u> 19 <u>86</u> to <u>7-</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>7-14-</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | |
| 22b SIGNATURE Dr. Alexander Bogdaschewsky | | | | 22c. DATE SIGNED 7-14-86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS 3001 S. Hanover Street. | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 7/17/86 | | 23c NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Rossville Baltimore Md. | | 23e DATE REC'D. BY REGISTRAR JUL 16 1986 | | 23f REGISTRAR'S SIGNATURE | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221 | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption plates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove companion pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 20100 | |
|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GOLDIE FISHER WOOLFORD | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 30 86 | | 2b. HOUR 2:55p M | | | |
| 3. SEX FEMALE | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 2 8 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2529 Christian Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13a. STATE Maryland | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2529 Christian Street 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Isaac Zunikoff | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanny Levinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-4902 | | 17. INFORMANT ADDRESS Elliot Woolford 346 S. Smallwood St. 21223 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC RENAL CELL CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 86 , to 7/23 , 19 86 , that (I) (we) lost saw the deceased alive on 7/23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Varma, MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/31/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Varma | | | | 22e. ADDRESS University Hospital 3rd Flr | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge MemPark | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | | ADDRESS 4107 Wilkens Ave. 21229 | | 25a. DATE REC'D. BY REGISTRAR AUG 1 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Glenn Davidson-Randall</i> | | | |

00-13489

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 20101

| | | | | | |
|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| GERTRUDE WORMSER | | JULY 18, 1986 | | 6:45 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| FEMALE | WHITE | AUG. 31 st , 1883 | 102 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | USA | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | EDGEWOOD NURSING HOME | SALESPERSON | CLOTHES | | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS / ZIP CODE | |
| MARYLAND | BALTO. | BALTIMORE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 2601 MADISON AVE. #21207 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| SIGMUND WORMSER | | HANNAH UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 215-10-6236A | | SYLVAN WORMSER | |
| | | 3424 BIRCH HOLLOW RD. | | BALTO., MD 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> | | | | | <u>years</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> 19 <u>86</u> , to <u>7-18</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-16</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Robert Stoner M.D.</u> | | | | 7-19-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| ROBERT STONER, M.D. | | Suite 506 120 Sister Pierre Dr. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | JULY 21, 1986 | | HEBREW FRIENDSHIP | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | JUL 25 1986 | | <u>Sol Levinson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-11840

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|-------|--|--|--|--|---|-----------------------|--|--|---|--|--|------------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kenneth | | | FIRST | | | MIDDLE | | | LAST Womack | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7/ 1/ 19 86 | | | 2b. HOUR M A P M | | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 30 1938 | | 6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 7/ 4/ 1986 | | | 2d. HOUR M A P M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2547 McCulloh St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 2547 McCulloh Street 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Womack | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leola Waters | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | | | | | 16b. SOCIAL SECURITY NO. 213-32-5151 | | | | | | 17. INFORMANT ADDRESS Clifton Womack 4110 Ridgewood Apt 1 B | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic Alcoholism & Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE _____ | | | | | | | | | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7/5/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE 7/9/86 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | | | | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Home West | | | | | | ADDRESS 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1986 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i> | | | | | | | | | | | | | | | | | | | |

STATE
MD

DO NOT WRITE

CHIEF W. B. DOW

(213)

0-13316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 86-20103 | | | |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE WOODS | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 17, 1986 | | 2b. HOUR 10:20 P ^M | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 31 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mill Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE Maryland | | | |
| 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2039 E. Eager Street 21205 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jim Woods | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Foster | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | |
| 16b. SOCIAL SECURITY NO. 247-32-6195 | | 17. INFORMANT Lizzie Woods | | | | ADDRESS 810 N. Castle Street | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>HYPERTENSION TOBACCO</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo 13 y | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10/86</u> 19 <u>86</u> to <u>7/18</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/10/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE <u>Stevie M. Holland</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22c. DATE SIGNED 7/18/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVE M HOLLAND | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL BALTO., MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Md Veteran Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1986 | | 25b. REGISTRAR'S SIGNATURE | |
| 1101 East North Avenue | | | | | | | |

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

U. S. DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D. C.

Very respectfully,
Yours very truly,
[Signature]

00-12098

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20104

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) BB Woodward | | | 2a DATE OF DEATH MONTH DAY YEAR 4/21 86 | | | 2b HOUR 8¹⁰ A.M. | | | |
| 3 SEX M | | 4 RACE black | | 5 DATE OF BIRTH MONTH DAY YEAR 4 21 84 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 0 0 | | IF UNDER 24 HRS. HOURS MIN. 55 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | |
| 10 CITY OR TOWN OF DEATH Balto | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE md. 13b COUNTY MD 13c CITY OR TOWN Balto. 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 4710 Wakefield Rd 21226 | | | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vida Woodward | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT ADDRESS | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **respiratory insufficiency**

DUE TO, OR AS A CONSEQUENCE OF

(c) **prematurity**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

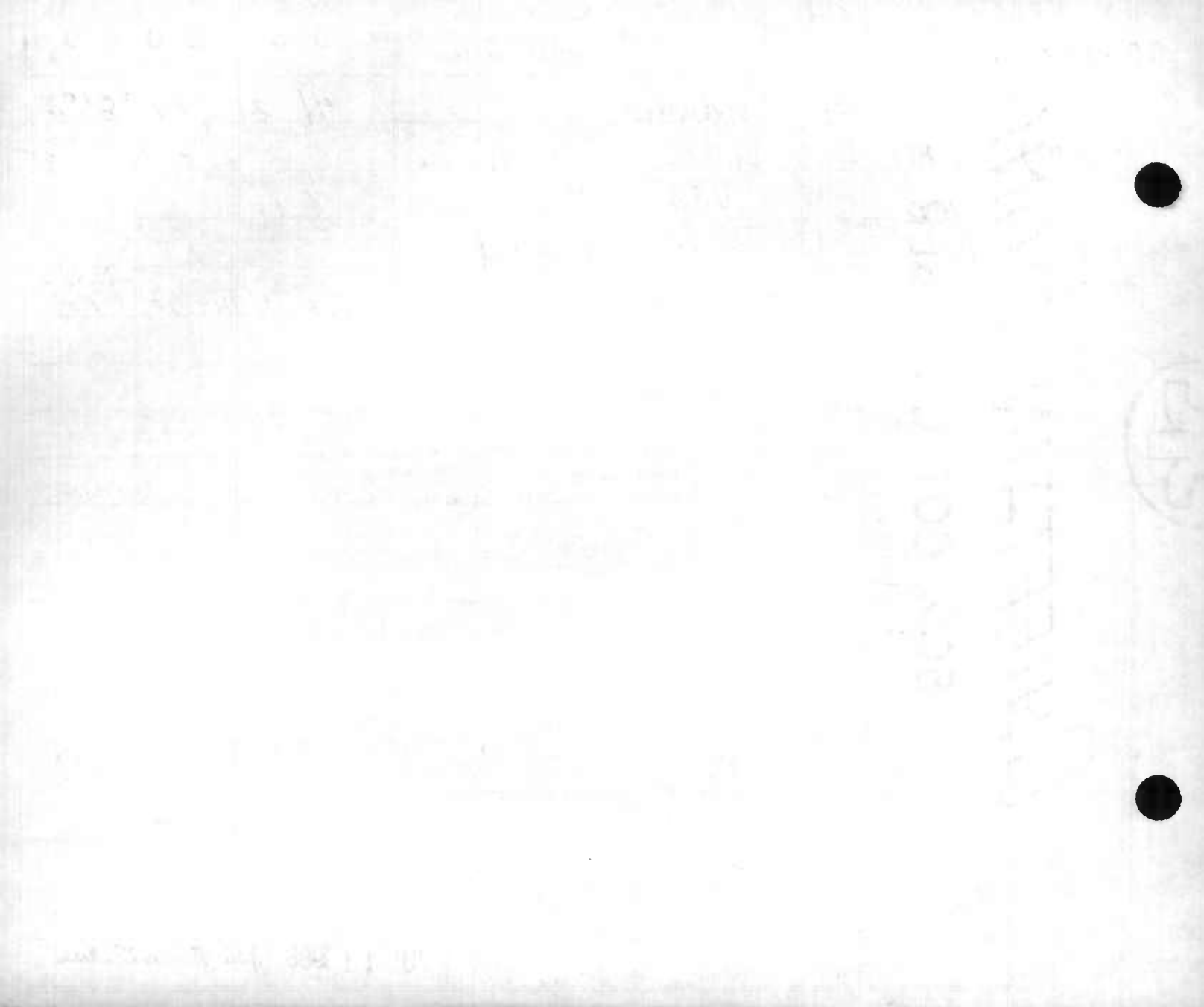
0**55min****55min**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a DATE OF OPERATION — | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Apr 20 19 86 to Apr 21 19 86 , that (I) (we) last saw the deceased alive on Apr 21 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b SIGNATURE Debra Counts, MD | | | | DEGREE | | 22c DATE SIGNED 4-21-86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) COUNTS | | | | 22e ADDRESS Sinai Hospital, Baltimore | | | |

| | | | | | | | |
|---|--|----------------------------|--|-----------------------------------|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b DATE 6-26-86 | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a DATE REC'D BY REG. (PART 25) REG. NO. SIGNATURE JUL 11 1986 Julia Denson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

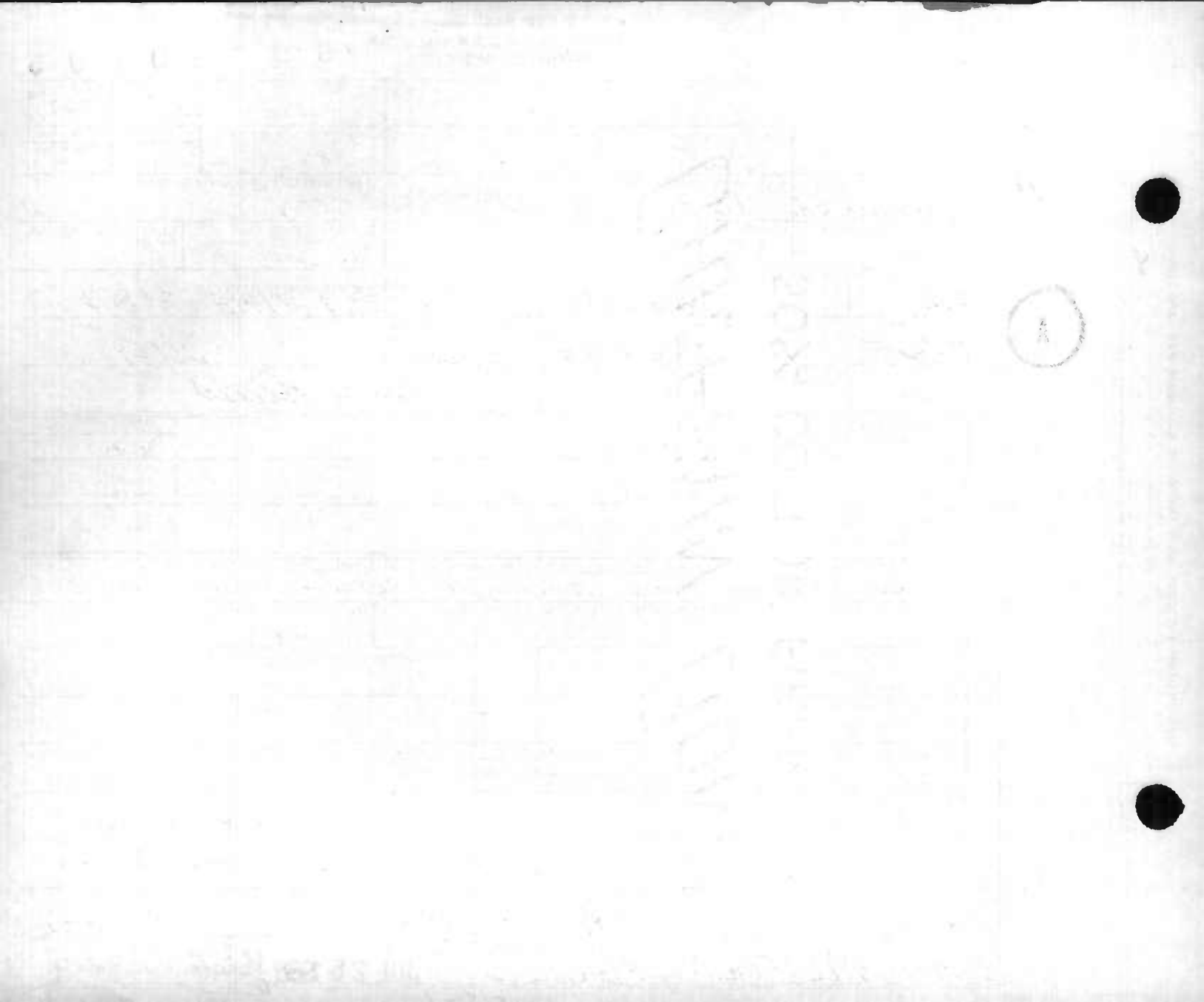
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 19.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|---------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>FOR STATE REGISTRAR</p> <p>Item 4</p> <p>Phone 7-90-86 CN</p> </div> <div> <p>REG. NO. 8 6 2 0 1 0 5</p> </div> </div> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| PEARL | | | | | 7 20 86 | | | 7:27 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| F | | White | | 3 21 04 | | 82 YRS | | MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| McCAYSVILLE, GA. | | U.S.A. | | | | CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | ST JOSEPH'S HOSPITAL | | | | HOUSE WIFE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| GA. | | | | BLUE RIDGE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RT. 1 BOX 14A 30513 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| JESSE T. STANDRIDGE | | | | EULEMA DOOLY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 409-01-8333 | | FAMILY RECORDS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) HYPOTENSION | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) SEPSIS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ASPIRATION | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, ADULT RESPIRATORY DISTRESS SYNDROME | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7PM 20 AUG 1986, to 7:27 PM 20 AUG 1986, that (I) (we) lost saw the deceased alive on 20 AUG 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| Henry Fessler | | | | | | | | 7/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| HENRY FESSLER | | | | | RESP DIVISION JOHNS HOPKINS HOSPITAL BALT. MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| BURIAL | | | | | COPPER RIDGE MEM. | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | GA. | | |
| 24. FUNERAL DIRECTOR | | | | | 25. DATE REC'D. BY REGISTRAR | | | | |
| EVANS CHAPEL OF MEMORIES PARKVILLE, MD | | | | | JUL 25 1986 | | | | |
| | | | | | 25. REGISTRAR'S SIGNATURE | | | | |
| | | | | | Julia Davidson-Randall | | | | |

00-13665

999999



00-12978

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20106

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WOODROW GRANT (WOODY) | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 15, 1986 | | | 2b. HOUR 12:10 ^P | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 2 15 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/a | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1305 EDEN STREET 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GRANT WOODY SR. | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST HENRITA FORESTER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 217098821 | | 17. INFORMANT ADDRESS SHIRLEY TATUM 3154 RAVENWOOD AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA of LUNG 6 months DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 4, 1986, to July 15, 1986, that (I) (we) lost saw the deceased alive on July 15, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Eric Brown MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/15/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Brown MD | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/14/86 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANSOWNE MD. | | | |
| 24. FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC. 1101 EAST NORTH AVENUE | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

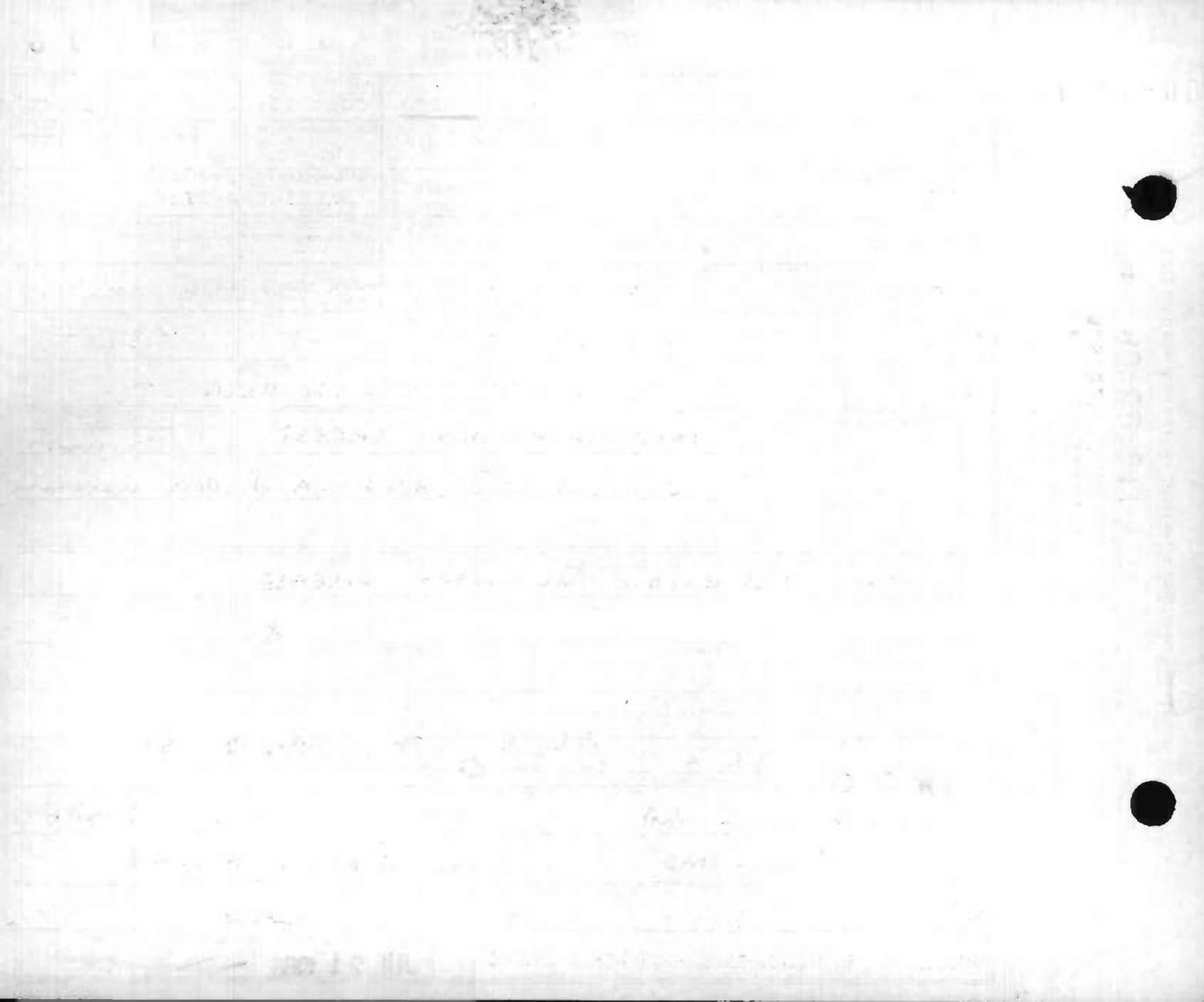
MEDICAL CERTIFICATION

119 07 06
GRANT, WOODROW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP



00-14076

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20107

FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ERNEST H. WRIGHT | | 2a. DATE OF DEATH MONTH 7 DAY 28 YEAR 86 | | 2b. HOUR 9:30 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 01 DAY 07 YEAR 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL 21218 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE Maryland | 13b. COUNTY --- | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3662 Keswick Road 21211 |
| 14. FATHER'S NAME FIRST Ernest MIDDLE H. LAST Wright, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST Ann MIDDLE Mildred LAST (unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 218-03-3574 | 17. INFORMANT ADDRESS Grace Wright 3662 Keswick Road 21211 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESP ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC LUNG CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 21g. I certify that (I) this hospital attended the deceased from 7/23 19 86 to 7/28 19 86 that (we) lost saw the deceased alive on 7/23 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.) | | | | |
| 22a. SIGNATURE L. I. Kitchen M.D. | | DEGREE | 22c. DATE SIGNED 7/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. I. KITCHEN M.D. | | 22e. ADDRESS 201 E. UNIVERSITY PARKWAY | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/31/86 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1986 | 25b. REGISTRAR'S SIGNATURE Jana Davidson-Rondelle | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other incident, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8620108

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ETHEL WRIGHT | | | 2a. DATE OF DEATH MONTH 7 DAY 21 YEAR 86 | | 2b. HOUR 6:23 AM |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH 3 DAY 13 YEAR 11 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT GENER. HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MD. 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2400 ANNUR CT 21430 | | |
| 14. FATHER'S NAME FIRST JAMES MIDDLE LAST BARRET | | 15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE LAST CARPER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS 3001 S. HANNOVER ST | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/20 , 19 86 , to 7/21 , 19 86 , that (I) (we) last saw the deceased alive on 7/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE John D. Milto MD | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. MILTO MD | | | | 22e. ADDRESS 3001 S. HANNOVER ST. BALTIMORE MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F.H ADDRESS 1913 W. Baltimore St. | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE | | 25a. DATE REC'D. BY REGISTRAR JUL 25 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

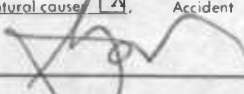

BP

00-12826

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

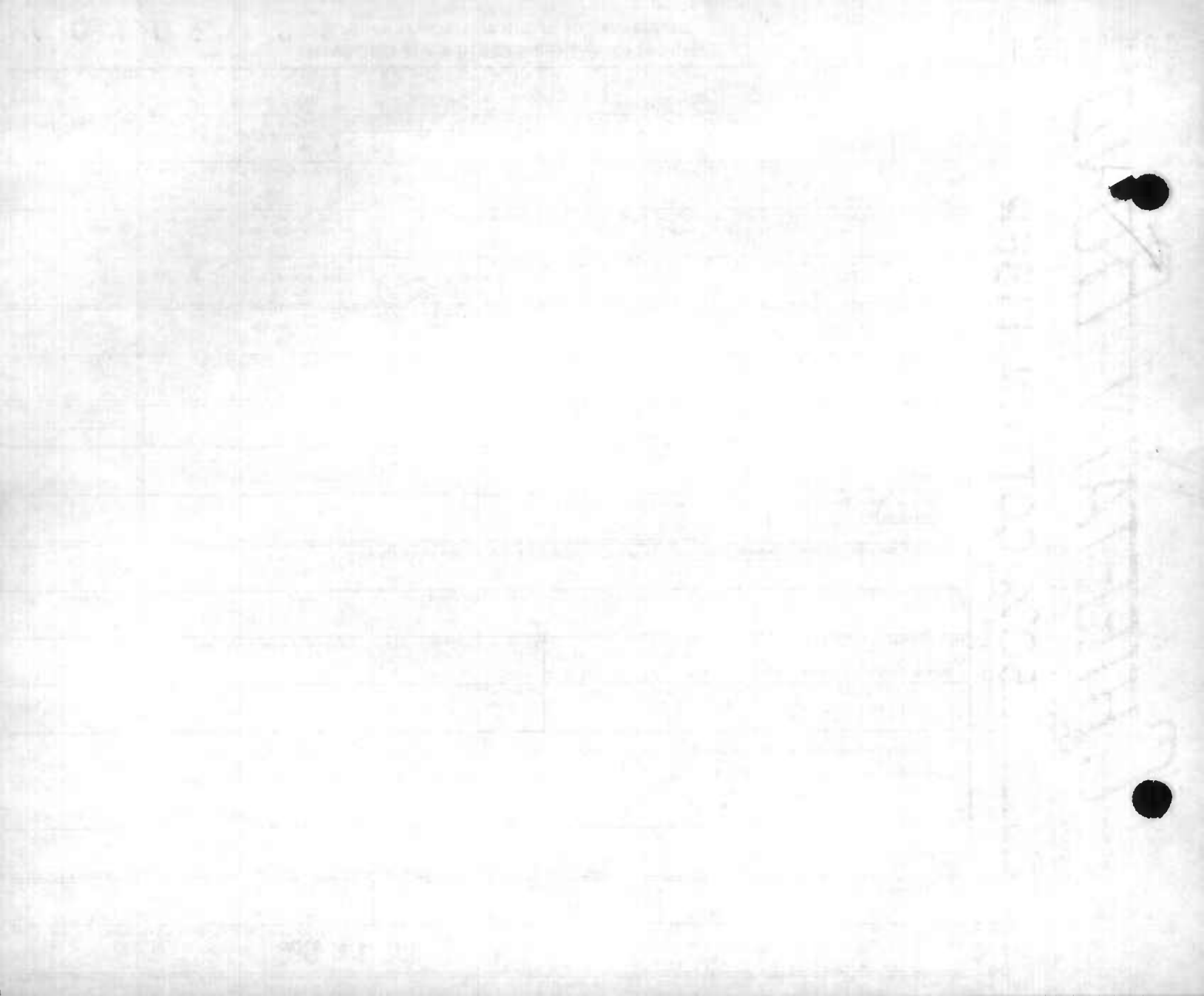
20109

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|--|------------------|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Everett W. Wright | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7/ 16/19 86 | | | 2b. HOUR 10:47 P M | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 6 24 1921 | 6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 16/1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS Beth Steel |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Wright | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pear Mason | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-05-5318 | | 17. INFORMANT ADDRESS Hattie Wright 1030 N. Payson Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 7/17/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 18 1986 | | 25b. REGISTRAR'S SIGNATURE  | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (S))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

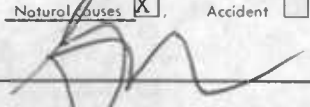
1- FOR
STATE
REGISTRAR


| | | | | | | | | |
|---|------------------|--|--|---|--|---|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Arthur Wright, Jr | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7/ 24/ 19 86 | | | 2b. HOUR 11:45 A M | | |
| 3. SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 1 5 22 | 6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 7/ 24/ 19 86 | 2d. HOUR 11:45 A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 35 S. Hilton St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City |
| 13a. STATE Md | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Wright | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Wright | | | 13e. STREET ADDRESS 35 S. Hilton Street 21229 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-16-9376 | | 17. INFORMANT ADDRESS Johnnie L. Wright 738 N. Grantley | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

| | |
|---|--|
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | ADDRESS 111 Penn St. |

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/28/86 | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown |
| 24. FUNERAL DIRECTOR NAME March Funeral Home West | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1986 | |
| ADDRESS 4300 Wabash Avenue | | 25b. REGISTRAR'S SIGNATURE  | |

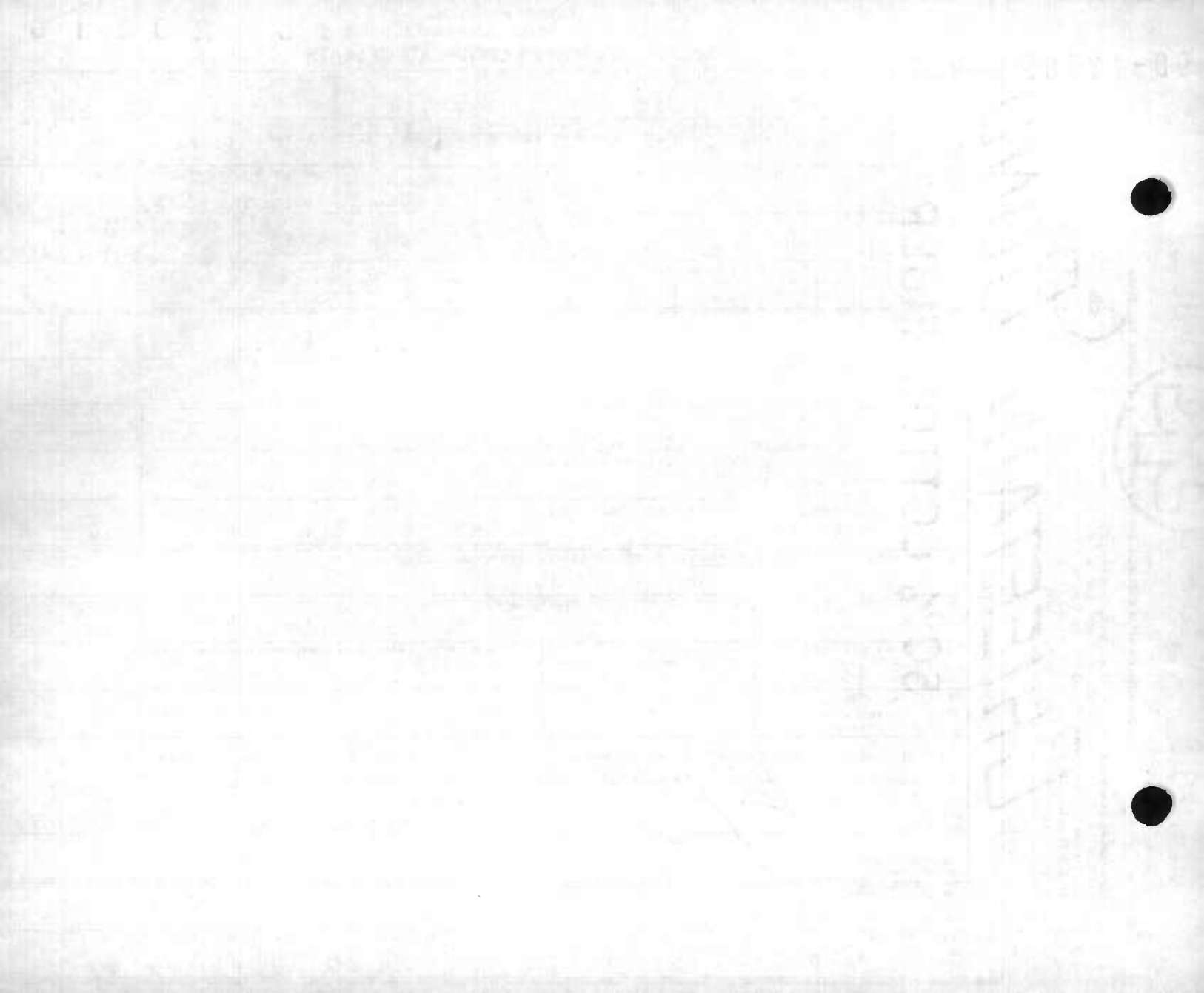
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



00-12135

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) William P. Wright | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 3 1986 | | | 2b. HOUR M 5:32P M | | |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 1950 | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 3 1986 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2408 Elsinore Avenue 21216 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roscoe Wright | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annette Handy | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-48-3525 | | 17. INFORMANT Roscoe M. Handy | | ADDRESS 705 N. Chapel Gate La. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Gunshot wound to chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR <u>XX</u> MONTH DAY YEAR 5 P.M. 7 3 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bar | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1300 Laurens St. Baltimore MD. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>Margie M. Yule</u> | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 7/4/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn St. Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F. H West 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 11 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u> | | |

DAVID

1941

MARY

1942



1943

1944

00-14180

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 20112
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | DARRYL EMMETT WYATT | | 07 23 86 | | 5:50 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| MALE | | BLACK | | 07 08 47 | | 39 YRS | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NEW JERSEY | | U. S. A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | GOOD SAMARITAN HOSPITAL | | Retail Store Mgr. | | Food Arama | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | Baltimore | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Walter Alvin Wyatt | | Josephine Primas | | No. | | 216-50-4632 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Mrs. Kathy O. Wyatt | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End Stage Renal Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Insulin Dependent Diabetes Mellitus</u> | | | | | |
| 6805 Bonnie Ridge Drive Dr. Baltimore, Md. 21209 | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>7/22/86</u> 19 <u>86</u> to <u>7/23</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| | | Ram Lal Mittal MD | | 7/23/86 | | | |
| 22d. PHYSICIAN'S NAME | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | |
| RAM LAL MITTAL | | 5601 Loch Raven Blvd. BALTIMORE, MD, 21239 | | Burial | | 7/30/1986 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. NAME OF CEMETERY OR CREMATORY | | 23f. LOCATION | |
| Md. National Mem. Pk. | | City or Town | | | | City or Town | |
| Laurel, Maryland | | COUNTY | | | | COUNTY | |
| | | STATE | | | | STATE | |
| 24. FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NUTTER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | AUG 1 1986 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

62-100

BALTIMORE CITY

U. S. A.

NEW YORK

RETAIL STORES, 1000 ALYD
1805 Penna. Ave.
Mr. Baltimore, Md. 21202

1000 BALTIMORE, MD. 21202

BALTIMORE

BALTIMORE

Prima Josephine
1805 Penna. Ave.
Mr. Baltimore, Md. 21202

Alvin West

Walter

21-50-4033 Mrs. Mary G. West Baltimore, Md. 21202

No.

landed

landed

landed

2801 Gympse Lane, Baltimore, Md. 21216
Walter & Sons, Baltimore, Md.
Baltimore, Md. 21202

00-11641

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8 6 2 0 1 1 3

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---------------------------|--|--|--|--|--|---|--|--|-----------------------------------|--|--|---------------------------------------|--|--|---------------------------------------|--|--|---------------------------------------|--|--|------|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS. | | | | | | | | |
| JAMES C. WYATT | | | MALE | | | BLACK | | | 7 8 1919 | | | 66 YRS | | | MONTHS | | | DAYS | | | HOURS | | | MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13. BALTIMORE CITY OR COUNTY OF DEATH | | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | | 15. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | | BALTIMORE | | | BON SECOURS HOSPITAL | | | PROCUREMENT AGENT | | | U. S. | | | BALTIMORE, MARYLAND CITY | | | BALTIMORE, MARYLAND CITY | | | BALTIMORE, MARYLAND CITY | | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 17. FATHER'S NAME | | | 18. MOTHER'S MAIDEN NAME | | | 19. STREET ADDRESS / ZIP CODE | | | 20. STREET ADDRESS / ZIP CODE | | | 21. STREET ADDRESS / ZIP CODE | | | 22. STREET ADDRESS / ZIP CODE | | | 23. STREET ADDRESS / ZIP CODE | | | | | |
| MARYLAND | | | William V. Wyatt | | | Addie Elizabeth Paige | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | 13f. STREET ADDRESS / ZIP CODE | | | 13g. STREET ADDRESS / ZIP CODE | | | 13h. STREET ADDRESS / ZIP CODE | | | | | |
| BALTIMORE | | | BALTIMORE | | | BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Baltimore, Maryland 21216 | | | Baltimore, Maryland 21216 | | | Baltimore, Maryland 21216 | | | Baltimore, Maryland 21216 | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 17. SOCIAL SECURITY NO. | | | 18. INFORMANT | | | 19. ADDRESS | | | 20. ADDRESS | | | 21. ADDRESS | | | | | |
| William V. Wyatt | | | Addie Elizabeth Paige | | | Yes | | | WW II | | | Mrs. Edythe Wyatt | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. ADDRESS | | | 19. ADDRESS | | | 20. ADDRESS | | | 21. ADDRESS | | | 22. ADDRESS | | | | | |
| Yes | | | 223-26-1867-B1 | | | Edythe Wyatt | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | 2407 Harlem Avenue | | | | | |

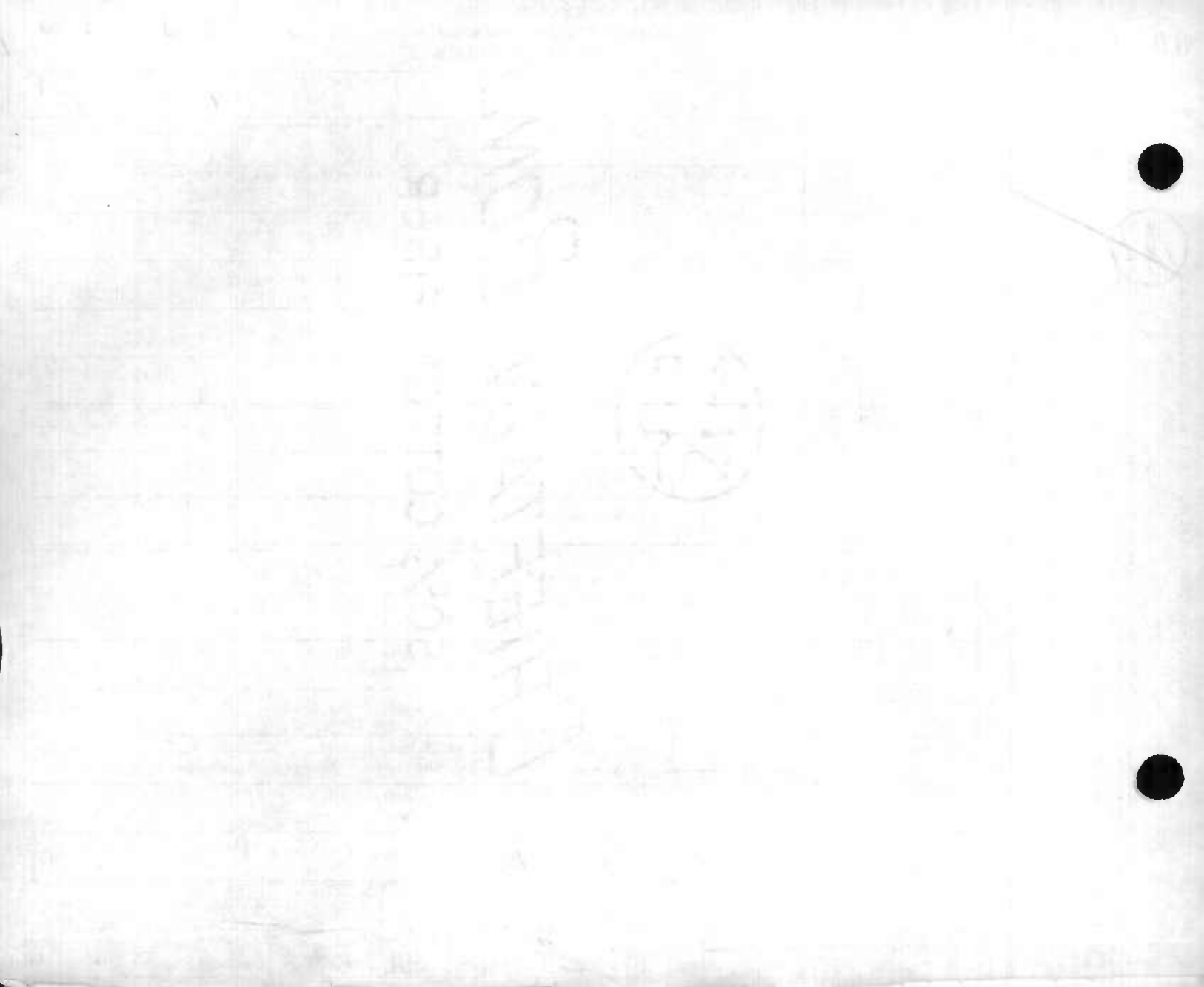
| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) SEPTIC SHOCK | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC CARINOMA To BONES | | | |
|---|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 6/23/86 | | LYTIC LESION BONE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 | | | |
| | | P.M. 19 | | NA | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | |
| | | NA | | NA | | COUNTY | |
| | | | | | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-6-1986 to 7-4-1986, that (I) (we) lost | | | | 22b. SIGNATURE | | | |
| saw the deceased alive on 7-4-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | DEGREE | | | |
| 22b. SIGNATURE | | | | ATTENDING MEDICAL STAFF | | | |
| SURGIT JULKA | | | | PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| SURGIT JULKA | | | | BON SECOUR HOSPITAL, BALTIMORE | | | |

| | | | | | | | |
|---|--|-----------|--|------------------------------------|--|---------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 7/12/1986 | | Arbutus Memorial Park | | Baltimore, Maryland | |

| | | | | | |
|--|--|-------------------------------|--|----------------------------|--|
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NUTTER & SONS FUNERAL HOME, INC. | | JUL 8 1986 | | Julia Davidson | |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | |



00-13576

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 0 1 1 4

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Eugene Wyche | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-21-86 | | | 2b. HOUR M | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9-12-1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2631 QUANTICO AVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR | | 12b. KIND OF BUSINESS OR INDUSTRY BALTO GRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2631 QUANTICO AVE | |
| 14. FATHER'S NAME WYLIE MIDDLE WYCHE | | | | 15. MOTHER'S MAIDEN NAME NANNIE MIDDLE BARRETT | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 213-30-8452 | | 17. INFORMANT Dorothy Wyche (WIFE) S/A | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>FLUID OVERLOAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL FAILURE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>86</u> to <u>July</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/17/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Luis F. Gimenez | | | | DEGREE M.D. | | 22c. DATE SIGNED 7/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS F. GIMENEZ | | | | 22e. ADDRESS 5601 LOCH RAVEN BLVD BALTO 21239 | | | |

| | | | | | | | |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | 23b. DATE 7-28-86 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD. | |
| 24. FUNERAL DIRECTOR NAME BROWN-THOMPSON | | | | 25a. DATE REC'D. BY REGISTRAR JUL 24 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE JAMES W. WILSON | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

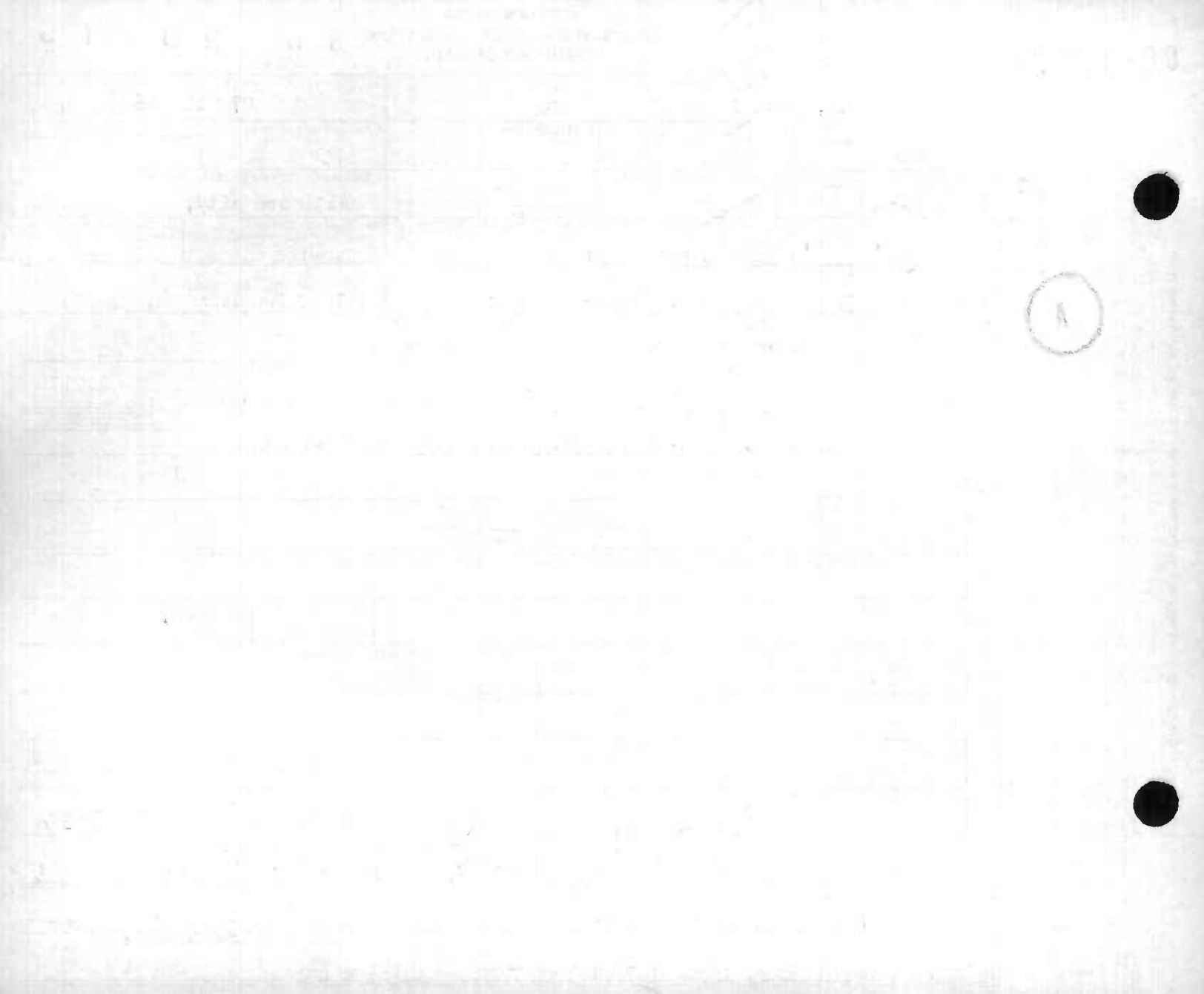
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 0 1 1 5

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) IL DONG YOM | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 12 86 | | | 2b. HOUR 4:04P M | | | |
| 3. SEX FEMALE | | 4. RACE KOREAN | | 5. DATE OF BIRTH MONTH DAY YEAR 6 5 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea-Seoul | | 7b. CITIZEN OF WHAT COUNTRY? KOREAN | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH baltimore city, MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4610 C Pen Lucy Rd. 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Man Young Yom | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ae Youl Lee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Chun Young Chung 2211 Reisterstown Rd. 21217 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Alvin S. Madarang | | | DEGREE | | RESIDENT | | 22c. DATE SIGNED 7-12-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALVIN S. MADARANG | | | 22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVE, BALT. MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY Yom Family Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Kyeong Gi Province Korea | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1986 | | 25b. REGISTRAR'S SIGNATURE | | |

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00-13021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 20116

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) George Edward Young Jr. | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 14 1986 | | | 2b. HOUR 8AM | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 01-24-30 | 6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS. | IF UNDER 1 YR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 14 1986 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Johns Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1842 Gay Street 71205 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Edward Young Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Hopkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO, OR UNKNOWN) UNKNOWN | | | 16b. SOCIAL SECURITY NO. 216-24-3732 | | 17. INFORMANT ADDRESS George Young Sr. 7418 Village Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Ethanolism</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>W. M. Zane</i> | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 7/14/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. | | | ADDRESS 111 Penn St. Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F.H. | | | ADDRESS 1913 W. Baltimore St. | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1986 | | 25b. REGISTRAR'S SIGNATURE <i>John A. Thompson</i> |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20117

REG. NO.

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) GERALDINE YOUNG | | | 2a DATE OF DEATH MONTH 7 DAY 11 YEAR 86 | | | 2b HOUR 851 P. | | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH 1 DAY 11 YEAR 06 | | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MD | | | 13b CITY OR TOWN BALTIMORE | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS / ZIP CODE 808 St. Paul St. 21202 | | |
| 14 FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | | | 15 MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN) | | | 16b SOCIAL SECURITY NO. 216281083 | | 17 INFORMANT CHART ADDRESS 3001 S. HANOVER ST | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22 I certify that (I) (this hospital) attended the deceased from 5/23 , 19 86 , to 7-11 , 19 86 , that (I) (we) last saw the deceased alive on 7-11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this body of death. | | | | | | | | | |
| 22b SIGNATURE John D. Milto MD | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 7/11/86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. MILTO | | | | | 22e ADDRESS 3001 S. HANOVER ST Baltimore 21202 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b DATE 7-14-86 | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| 24 FUNERAL DIRECTOR NAME Anatomy Board | | | | | ADDRESS Balto., Md. | | 25 DATE REC'D. BY REGISTRAR JUL 21 1986 | | 25 REGISTRAR'S SIGNATURE Julia Dendron-Rudolph |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Michael



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove contents of pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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|---|--|---|---|--|---|---|--|--|--|------------------------------------|-------------------------------|-------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 86 | | 20118 | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Young | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 18 86 | | | | | 2b. HOUR 2:00 PM | | | |
| 3 SEX female | | 4 RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 17 1918 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1702 Presbury Street | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1702 Presbury Street 21217 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mack Rice | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Epps | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-18-0625 | | 17. INFORMANT ADDRESS Alma M. Hill 2652 Marbourne Avenue | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hepatic Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Ca</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo</u> <u>11</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> 19 <u>86</u> to <u>7/18</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>William C. Waterfield</u> | | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>7/21/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William C. Waterfield MD</u> | | | | | 22e. ADDRESS <u>5440 St. Johns Hospital</u> <u>900 Canton Ave. Balt Md 21229</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | | | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue | | | | | 25a. DATE REC'D BY REGISTRAR JUL 22 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Davidson</u> | | | | | | |

0-13073

100% COTTON
MADE IN U.S.A.
WASH & TUMBLE DRY

JUL 23 1966

00-11954

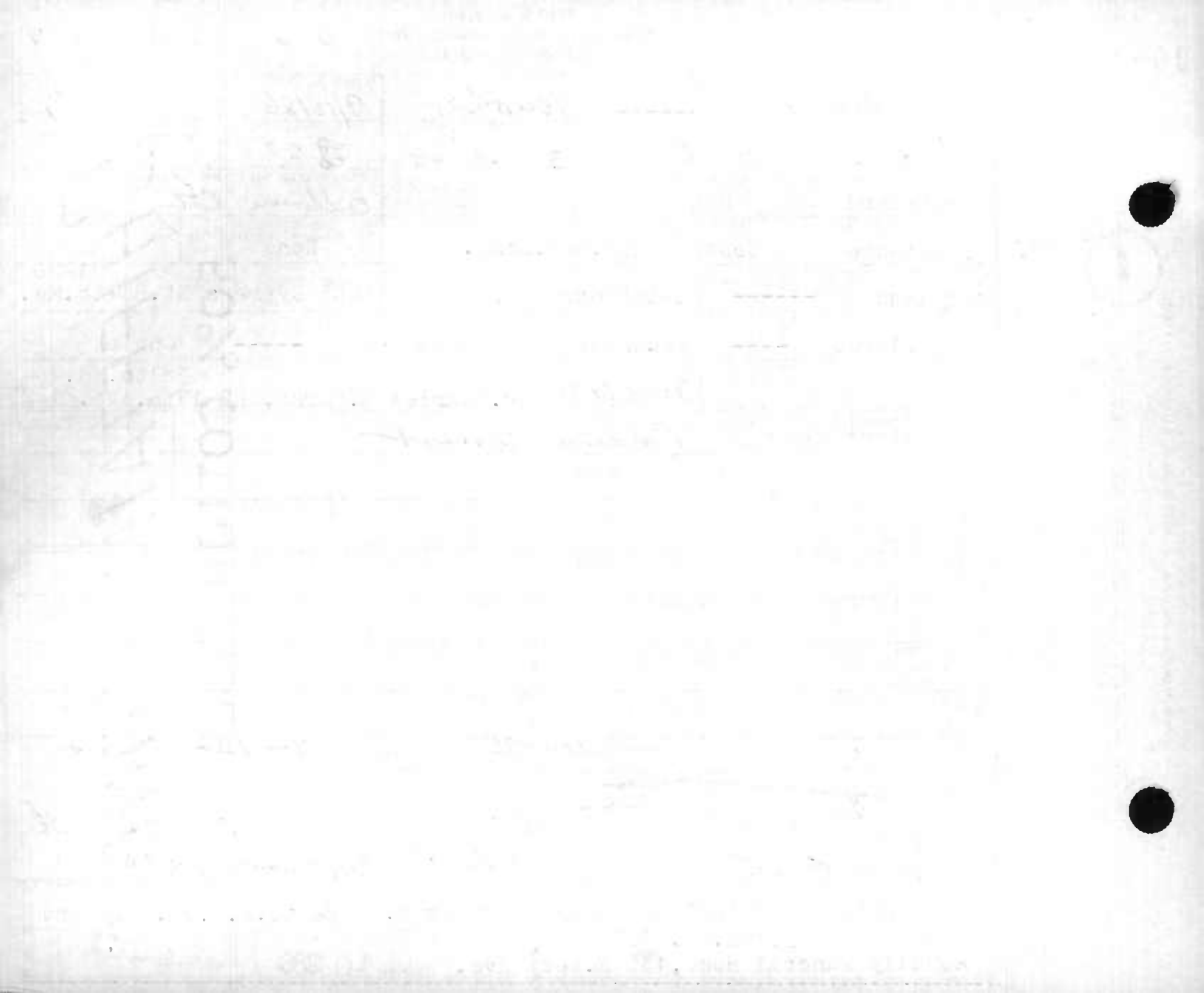
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8620119 | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Albert Youngbar</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7/10/86</i> | | | 2b. HOUR <i>12:30 AM</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 22 88</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78 83</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balto. Gen. Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>None</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Pierce Youngbar</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Johanna Cunish</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>214660313</i> | | 17. INFORMANT <i>Mr. Charles A. Parks</i> | | ADDRESS <i>Balto. Md. 105 17th. Ave. 21225</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>7-10-86</i> , 19____, to <i>7-10-86</i> , that (a) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>7-10-86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AMAEFFULE</i> | | | | | 22e. ADDRESS <i>SBCGH, Baltimore, M.D.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/12/1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cmt.</i> | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Balto. A.A.Co. Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>McCully Funeral Home, 130 E. Fort Ave.</i> | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 10 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |



00-12534

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC-10

86 20/20

| | | | | | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR A.M. | |
| DECEASED NAME (TYPE OR PRINT) | | 7-12-1986 | | 12:45 M | |
| FIRST MIDDLE LAST | | 3. SEX | | 4. RACE | |
| Sophia | | Female | | White | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | |
| 9-17-1895 | | 90 | | Poland | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| | | Balto. City | | Balto. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 2213 Pelham Ave. | | Homemaker | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Balto. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Chocie jowski | | Unknown | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 216-01-7057D | | Laura Yurkowski, Same as 13c | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) BALTO. CITY KLATSKINS Tumor | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, DIABETOS. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977 to 1986, that (I) (we) lost | | | | | |
| saw the deceased alive on 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Donato A. Vargas, Jr., M.D. | | M.D. | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| | | 4706 Harford Rd. | | JUL 15 1986 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7-15-86 | | Moreland | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Balto., Md. | | | | Julia Davidson | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | |
| | | Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7081-71-0

402 *Journal of Management Inquiry* 15(4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|------------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| FRANK R | | ZALLAR | | 7-1-86 5:25 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | White | 1-2-15 | | 71 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | U.S.A. | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | University of Md. Hospital | | Painter | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| Md. | | Baltimore | | 869 Hollins St. 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Frank Zallar | | Theresa | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 192-01-6483 | | Luth M. Zallar 869 Hollins St. Balt. Md. 21201 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST. | | | | | 5-10 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASPERGILLIS PNEUMONIA | | | | | 10-14 d. |
| DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEUKEMIA | | | | | 3 mon |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 5/13, 1986, to 7/1, 1986, that (1) was last seen by the deceased on 7/1, 1986, and that in my opinion death occurred on the date and hour and from the causes stated above. (If viewed, view the body after death.) | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| R. Kennedy | | MD | | 7/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| KENNEDY | | UMCC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Buried | | 7-5-1986 | | Glorious Cemetery | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 24c. LOCATION CITY OR TOWN COUNTY STATE | |
| J. J. Cowan & Son Inc. | | Baltimore 21223 | | Glorious Cemetery, A.A. Co. Md. | |
| 25a. REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| JUL 8 1986 | | | | | |

10/1/77

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00-11697

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 20122 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|-----|--|------|--|----------|--|--|--|----------------------------|--|------------------|--|-------|-------|------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST | | | | | MIDDLE | | | | | LAST | | | | | | | | | | | | | | |
| JOSEPH | | | | | L | | | | | ZEBACK | | | | | 7 4 86 | | | | | 232 P M | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| MALE | | | | | CAUCASIAN | | | | | MONTH 1 DAY 14 YEAR 26 | | | | | 60 YRS. | | | | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | |
| PENNA. | | | | | USA | | | | | | | | | | Baltimore County MD. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| BALTIMORE | | | | | SOUTH BALTIMORE GENERAL HOSP. | | | | | LONGSHOREMAN | | | | | LOCAL | | | | | UNION 333 | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSE, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. CITY OR TOWN | | | | | 13c. INSIDE CITY LIMITS? | | | | | 13d. STREET ADDRESS / ZIP CODE | | | | | | | | | | | | | | |
| MD | | | | | BALT | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 1307 Chapel Hill Drive 21237 | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| FIRST | | | | | MIDDLE | | | | | LAST | | | | | FIRST | | | | | MIDDLE | | | | | LAST | | | | |
| PETER | | | | | ZEBACK | | | | | VIOLET | | | | | GARY | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | ADDRESS | | | | | | | | | | | | | | |
| No | | | | | 219-18-9397 | | | | | Jean Makowski (sister) same address | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DILATED CARDIOMYOPATHY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) FIVE-VENTRICULAR FAILURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | STREET | | | | | CITY OR TOWN | | | | | COUNTY | | | | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/16/86 to 7/4/86 that (I) (we) lost saw the deceased alive on 7/4/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Michael E. Collier, M.D. | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 7/4/86 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| MICHAEL E. COLLIER, M.D. | | | | | | | | | | 3001 S. HANOVER ST. BALT, MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | | | | | | | | | | | |
| Burial | | | | | 7/8/86 | | | | | Oak Lawn | | | | | Baltimore COUNTY Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Schimunek Funeral Home, Inc. | | | | | | | | | | JUL 8 1986 | | | | | | | | | | John J. ... | | | | | | | | | |
| 3331 Brehms Lane, Balto. Md. 21213 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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WINTER



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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

2 0 1 2 3

| | | | | | | | |
|---|--|--|--|---|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Zennadiu Zientuk</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 2, 1986</i> | | 2b. HOUR M | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 27, 1918</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN. <i>67</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>603 S. Patterson Park Ave.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Key Punch Oper.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Rush</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Theresa Otremba</i> | | 16. STREET ADDRESS / ZIP CODE <i>603 S. Patterson Pk. Ave 21224</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-01-2763</i> | | 17. INFORMANT ADDRESS <i>Albert Zientuk 603 S. Patterson Pk.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>SEPTICEMIA.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>MALIGNANT CHOROMA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>EXTENSIVE DEEP BITES ULCERS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10 A.M. 1986</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1979</i> to <i>June 1986</i> that (I) (we) last saw the deceased alive on <i>6-30-1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23. SIGNATURE <i>Emil Kfoury M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EMIL KFOURY M.D.</i> | | | | 25. ADDRESS <i>100 N. BROADWAY BALTIMORE, MD 21201</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7-5-1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>John M. Weber & Sons Inc. 401 S. Chester St.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>111 3-1986</i> | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

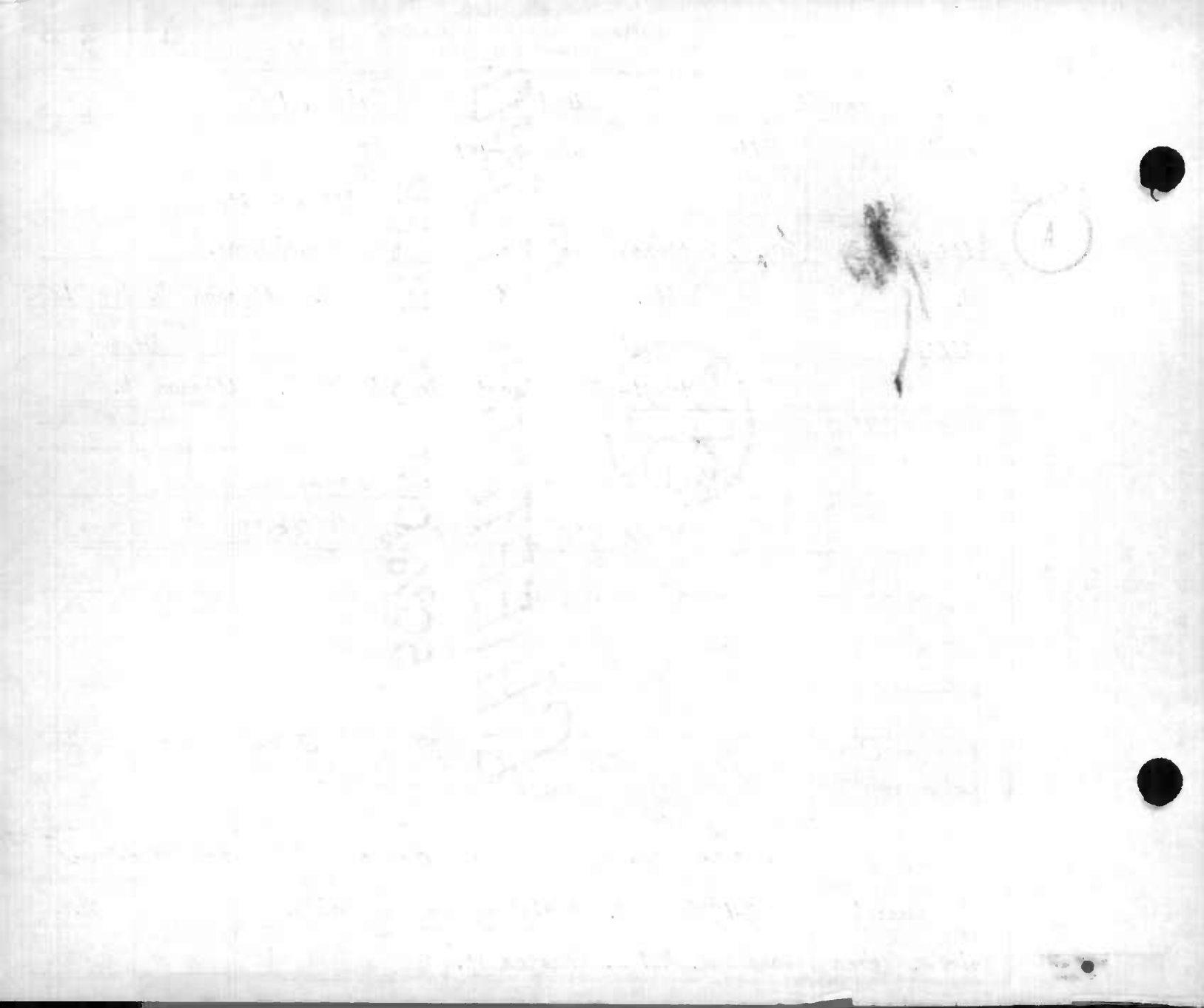
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be retained by the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-11936

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 20124

REG. NO.

| | | | | | | | |
|---|--|---|-------------------|--|--------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| RAYMOND F. ZINZELETA | | | | JULY 8, 1986 | | 7:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Male | White | March 9, 1929 | | 57 YRS | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore, Md. | U. S. A. | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (IF PLACE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | Attorney Corp of Engineer | | U.S. Army | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | |
| Md. | | Howard | Ellicott City | <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3330 Greenway Drive-21043 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Anthony - Zinzeleta | | | | Stella --- Kalokites | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. HOME ADDRESS | | | |
| Yes | | Korean War-215-28-1632 | | Wife: Ellicott City, Md. 21043. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | |
| IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) acute myelogenous leukemia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 8, 1986, to July 8, 1986, that (I) (we) last saw the deceased alive on July 8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| [Signature] | | | | MD | | 7/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Douglas G. Cole | | | | Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/12/86 | | Crest Lawn Gardens of | | Howard County, Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Sterling Funeral Home, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228 | | | | JUL 10 1986 | | [Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic cause of death, a medical examiner must be notified for notification of the coroner.

BP

